MEDICARE COVERAGE OF ALCOHOLISM TREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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MEDICARE COVERAGE FOR THE TREATMENT OF ALCOHOLISM

TUESDAY, JULY 27, 1982

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMMITEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press releases announcing the hearing and the opening statements of Senators Durenberger and Dole follow:]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON ALCOHOL TREATMENT COVERAGE UNDER MEDICARE

Senator Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on Medicare coverage for the treatment of alcoholism.

The hearing will be held on Tuesday, July 20 at 9:30 a.m. in Room 2221 of the Dirksen Senate Office Building.

Senator Durenberger said, "alcoholism and alcohol related problems have resulted in significant costs to our Nation, in terms of human as well as financial resources. It has been estimated that alcohol related problems have had a cost of $28 billion in lost productivity, $18.2 billion in health and medical services, and $7.3 billion due to auto accidents involving drunk driving. Twelve to fourteen million Americans are believed to be struggling with an alcohol problem and the American Hospital Association estimates that approximately one-half of all occupied beds in the United States were filled by people with ailments linked to the consumption of alcohol.

It has been estimated that as many as 15 percent of the elderly population, the primary recipients of medicare benefits, are believed to suffer from alcoholism. The Health Care Financing Administration, in fiscal year 1979, estimated that the medicare program paid about $100 million for the treatment of alcohol-based disorders and alcoholism.

Senator Durenberger said that, "there are various modalities, at a wide-range of costs, currently used to treat alcoholism. Also there is considerable variance in the coverage provided by private insurers."

Senator Durenberger went on to say that the Subcommittee would like to hear from the administration, providers of alcohol teatment—both in inpatient and outpatient settings—private insurers, and employers with employee assistance programs as well as individuals who have received treatment for alcoholism. The Subcommittee anticipates that the experiences and information provided at this hearing will be of great assistance in its deliberations as it seeks to determine the most appropriate coverage for alcohol treatment under the medicare program.

SUBCOMMITTEE ON HEALTH RESCHEDULES HEARING ON ALCOHOL TREATMENT COVERAGE UNDER MEDICARE

Senator Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health, announced today that the Subcommittee is rescheduling its hearing on

Medicare coverage for the treatment of alcoholism. The hearing was originally announced for Tuesday, July 20, 1982, at 9:30 a.m. The new date for the hearing is Tuesday, July 27, 1982.

Hearing will begin at 1:30 p.m. in Room 2221 of the Dirksen Senate Office Building.

Opening Statement of Senator Bob Dole—Hearing on Medical Coverage of Alcoholism Treatment

As late as 1952, health insurance coverage in this country was confined largely to inpatient care and did not include the treatment of alcoholism. As a result, alcoholics were admitted and received alcoholism treatment, but under a different diagnosis. In addition to the lack of adequate insurance coverage, those suffering from alcoholism were faced with a shortage of hospital based treatment programs and licensed and accredited residential treatment facilities. This situation has begun to change.

In recent years alcoholism treatment has received growing attention in both the public and private sectors. In the public sector the National Institute on Alcohol Abuse and Alcoholism was established in 1971 and played an active role in the developing treatment services and stimulating private insurance coverage for alcoholism treatment. Since 1970, 16 State legislatures have enacted mandatory health insurance coverage for alcoholism. Additionally, 18 States have required that health insurers provide, at the policyholder's option, coverage for alcoholism treatment.

In the private sector there has been an increasing awareness of the costs associated with alcoholism. These include lost production, motor vehicle accidents, higher life and health insurance premiums, increased crime, and greater involvement with the criminal justice system. In response to this recognition many employers have established employee assistance programs which include alcoholism treatment. The number of employers with such programs has increased rapidly within the last decade. For example, in 1972 only 125 of the fortune 500 companies had employee assistance programs. By the late 1970's, the number of companies and doubled. In addition, by 1977, 54 out of 61 Blue Cross health plans covered detoxification and 40 covered rehabilitation.

Problems with alcoholism exist in all aspects of our society, and can be found in any workplace or profession. The April, 1982 issue of the American Journal of Nursing contained a collection of articles directed towards the nursing profession. "Help for the Helper" provided not only a description of the problems with alcoholism faced by nurses, but also offered suggestions and examples of how employers and peers were confronting these issues.

Today we hear estimates of more than 14 million adults and adolescents regarded as alcoholics and problem drinkers. And this number is increasing by an estimated 200,000 per year. There are about 4,900 alcoholism treatment centers trying to meet the needs of these people. These centers vary in size and services and range from store front treatment centers to hospital-based units including freestanding alcoholism hospitals.

Though considerable progress has been made in providing greater coverage for alcoholism treatment and making treatment programs more accessible, many concerns still remain.

It is our duty to seek to determine how dollars used for alcoholism treatment under the medicare program can be used most effectively. We hope to learn much from today's witnesses about alcoholism treatment and coverage in both the public and private sector as we continue our review of the coverage issues under the medicare program.

Senator DURENBERGER. The hearing will come to order.

First, let me apologize for the 1-week delay in the hearing. I realize that many of you, not only the witnesses but those who are interested in the subject, had to change your schedules on short notice, and I want you to know that as chairman of the subcommittee I appreciate that.

I'm sure you know that last week got a little hectic with the tax and spending bill. You may not know that during the course of markup on the tax bill I opposed both the increase in cigarette taxes and liquor taxes. On the grounds of the New Federalism, these are tax sources that might best be left to the 50 States of this country.

You also may not know that I lost on cigarettes but you may not know the reason I lost. It was because members of the committee evidently felt that cancer and heart disease were a greater cost burden on the public than alcoholism. I doubt that. I don't need to recite for you all the staggering figures on alcoholism. It is a huge financial drain on our society. The annual alcohol-related expenditures on health services alone exceeded $18 billion. Lost productivity has cost our society another $28 billion a year.

But there is another, more tragic side to alcoholism. Dollars and cents don't begin to describe the despair that is associated with the disease, the despair that can only be told by the mother whose child was killed by a drunk driver, or by the children of alcoholics who have seen a parent's love turn into anger and abuse, or, the most tragic of all, the alcoholic himself or herself.

The human and economic suffering caused by this disease are mind boggling. Fortunately, we have made inroads. A lot has been done to reshape public thinking. Americans are increasingly recognizing alcoholism as a disease, and treatment programs are increasing in number around the country to rehabilitate alcoholics.

Sadly, in spite of these new programs and emphasis, one group of people has been largely ignored: The elderly have received little attention. Diagnosis is one problem. What is really alcoholism may be passed off in the elderly as senility, old age, or frailty. Referral for treatment and motivation for recovery are also deficient.

The major motivational factors for younger drinkers, like employment, a driving arrest, or the family, are less important among the elderly. But understanding and treatment of the older alcoholic is improving, thanks in large part to the emergence of alcoholism treatment as a highly dedicated and a highly respected field.

Not surprisingly, one of the big factors in shaping the growth of treatment programs has been insurance coverage. If insurance doesn't pay for a treatment, it is very difficult for that treatment to establish itself and to grow. And insurance coverage for alcoholism treatment is focused on the traditional model of inpatient care. If treatment is not delivered in a hospital, insurance generally will not pay. And medicare is no different. Practically speaking, medicare limits coverage for alcoholism to in-hospital treatment.

The expansion of coverage to include treatment in free-standing treatment centers was achieved in 1980 only to be repealed by last year's Budget Act. That provision was repealed with the best of intentions. Evidence does seem to indicate that residential treatment can be half as expensive as in-hospital care, and that's why Senator Long encouraged the expansion of benefits in 1980.

Yet, time and again we have seen evidence that expanding medicare coverage for less costly alternatives does not always translate into cost savings. New benefits are often a supplement, not a substitute. We build one layer of benefits on top of another without getting to the heart of the problem: How do we improve health care services while making that care more cost effective?

So that's why we're here today, to examine the benefit as it is now structured and to explore options for improving it.

I am delighted to have Congressman Mills with us today, both to hear about his personal triumph and to hear about his involvement with the National Council on Alcoholism.

As a Minnesotan I am especially proud to have Harold Swift of Hazelden with us today.

Minnesota is sometimes referred to as a Mecca when it comes to alcoholism treatment, and of course Hazelden is the granddaddy of them all.

I want to welcome all of our other witnesses and to thank them for being here today. We look forward to your special insights, and I know all of us have the same thing in mind—better and more cost-effective alcoholism treatment.

Well, with that dramatic beginning I'm going to go vote. Those of you who have stopwatches can see how fast I can do that. We will recess until I return.

[Whereupon, at 2:06 p.m., the hearing was recessed.]

AFTER RECESS

Senator **Durenberger**. The hearing will come to order, and our first witness will be Ms. Patrice Hirsch Feinstein, Associate Administrator for Policy, Health Care Financing Administration, accompanied by Dr. William Mayer, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, and others who will be introduced.

Ms. Feinstein?

Ms. **Feinstein**. That was a fast 10 minutes.

STATEMENT OF PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION

Ms. **Feinstein**. I appreciate the opportunity to be here today to discuss policies for the coverage of alcohol treatment under the medicare program. Accompanying me are Dr. William Mayer, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration; on his right, Mr. Marty Kappert, Deputy Associate Administrator for Operations in the Health Care Financing Administration; and on my left, Dr. Donald Young, Deputy Director of our Bureau of Program Policy.

The Department of Health and Human Services shares your concern, Mr. Chairman, about the many Americans—including the elderly and the disabled—who must cope with the serious problems of alcoholism and adverse health conditions resulting from it. The medicare program authorizes considerable coverage for treatment of alcoholism and medical problems associated with alcoholism. The benefits and services available for such treatment are similar to those available for coverage under medicare of any medical condition. The medicare statute does not provide a specific benefit for alcoholism or any other particular diagnosis, except for End Stage Renal Disease. Services are covered, however, because they are medically necessary and available in a covered setting.

By statute, medicare is primarily oriented toward covering acute conditions. Thus, the coverage of alcohol treatment is similarly focused.

Coverage for alcohol treatment is available in both general and psychiatric hospitals. Based on accepted medical practices, we have established guidelines for evaluating the types and duration of treatment received by medicare beneficiaries. These guidelines are provided to our contractors to apply as they monitor patient care. For example, in the course of treating a beneficiary for alcoholism a hospital could provide 2 to 5 days of detoxification. Also, it is possible that treatment will involve a combination of detoxification and rehabilitation. In such cases up to 3 weeks of care may be necessary. These timeframes provide an illustration of what is typically covered. Depending on medical necessity in the individual case, however, either less or more care may be covered.

Outpatient hospital services are available to medicare beneficiaries. As such, outpatient hospital services can be provided in the course of alcohol treatment. These services must be provided by a physician or incident to a physician's service.

In other outpatient settings such as freestanding alcohol treatment facilities, physician services and services which are an integral part of a physician's course of treatment may also be covered.

It is important to note that alcoholism services covered under medicare must be reasonable and necessary for either the diagnosis or treatment of the patient's condition. This is a general program requirement that applies to all services provided under medicare. Furthermore, accepted national and international medical references have classified alcoholism as a mental disorder. Therefore, the limitations that apply under medicare to the use of mental health services have been applied also to alcohol treatment. These restrictions include a limit of 190 days on the lifetime number of days of coverage available for inpatient care in a psychiatric institution. Also, coverage is permitted only for care that represents "active treatment." Finally, physician services for treatment of a mental disorder provided to an individual who is not an inpatient of a hospital are subject to a $250 annual payment limit.

HCFA continually reviews its policies and coverage guidelines to insure cost-effective delivery of services. The issue of alcohol treatment coverage is particularly complex, given that alcoholism in the elderly population is a serious problem; there are conflicting views regarding appropriate treatment methods; and treatment can be very expensive.

When potential problems with coverage guidelines or the provision of services are identified, HCFA attempts to review and resolve them. For example, increased awareness regarding treatment methods and questions raised by our contractors related to our alcoholism coverage guidelines have prompted us to clarify them. Revisions to these guidelines are currently in the final stages of promulgation within the Department. The Alcohol, Drug Abuse, and Mental Health Administration, with which we have worked closely, has approved our changes.

As we have developed these modifications, we have been careful to assure that effective, necessary alcoholism treatment methods will be covered in the most appropriate setting available.

The revised guidelines specify more clearly when inpatient alcohol treatment is appropriate. Also, these guidelines describe the coverage available in settings other than the inpatient hospital setting. For example, guidelines for the coverage of alcohol treatment services furnished to outpatients of a hospital are expanded. This revision will make clear that medicare payments are available for outpatient hospital services for alcohol treatment. This should foster greater efficiency in service delivery.

I would like to comment briefly on the issue of how much medicare funding is devoted to reimbursement for alcohol treatment.

It is very difficult to determine the level of medicare expenditures for conditions related to alcoholism. Data related to the types of services provided in noninstitutional settings such as physician services, are not available. Also, we cannot identify with certainty all conditions or diagnoses which result from alcoholism. A particular problem is whether the reporting of conditions related to alcoholism is accurate. Undoubtedly, the social stigma associated with such a diagnosis adversely impacts the accuracy of reporting. We certainly sympathize, however, with the need for patient privacy in such reporting.

Several years ago we did try to determine, within these constraints, how much medicare reimburses for alcoholism conditions. Our estimate included only diagnoses directly related to alcoholism. In 1979 dollars, these diagnoses accounted for approximately $90 million in expenditures for institutional care alone. If we inflate the 1979 figure based on medicare expenditure increases, the comparable 1982 level is $150 million. We expect that this estimate is low. If the cost to provide treatment in noninstitutional settings were included and the cost of treating alcohol-related conditions were considered, the total cost of treating alcoholism would likely be considerably higher.

As with other care provided to medicare beneficiaries, we have mechanisms to monitor alcohol services. Contractors review services based on our guidelines to ensure that utilization is not excessive and that treatment methods are medically appropriate.

Finally, I would like to discuss a major demonstration project which we have underway related to alcoholism. This 4-year study is a jointly funded project involving HCFA and the National Institute on Alcohol Abuse and Alcoholism. The project was initiated in September of last year. It will enable us to determine the feasibility and effectiveness of providing alcohol services under medicare and medicaid in a variety of settings.

Demonstrations will be conducted in six States. Approximately 122 settings will be involved. Reimbursement will be provided for alcohol services delivered in certain settings not currently covered. Emphasis will be placed on those noninstitutional settings which are potentially less expensive than the traditional institutional ones. We hope to learn about the costs of services in these settings compared to costs involved in service delivery by traditional providers such as hospitals.

We also hope to identify the impact of demonstration sites on the utilization of services of traditional providers; that is, will reimbursement to the new providers result in a shift of utilization from inpatient to outpatient facilities?

Finally, the project will provide some information on the quality of care provided in alternative settings.

In summary, I would like to emphasize that the Department is very concerned about the problem of alcoholism among the medicare population. Our coverage guidelines make clear that necessary treatment for alcoholism and related conditions is covered in a manner similar to other medical problems. Also, we are studying alternative treatment settings to determine their cost effectiveness.

Given your interest in this issue, Mr. Chairman, we would be pleased to keep the committee informed of the progress of this study, and we will look forward to working with you to make necessary improvements in the manner in which alcoholism services are covered for our patients.

I would be happy to answer any questions you may have.

Senator DURENBERGER. Thank you very much for your testimony.

[The prepared statement follows:]

STATEMENT OF PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION

I appreciate the opportunity to be here today to discuss policies for the coverage of alcohol treatment under the Medicare program. Accompanying me are Dr. William Mayer, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Mr. Martin Kappert, Deputy Associate Administrator for Operations in the Health Care Financing Administration (HCFA), and Dr. Donald Young, Deputy Director of our Bureau of Program Policy.

The Department of Health and Human Services shares your concern, Mr. Chairman, about the many Americans—including the elderly and the disabled—who must cope with the serious problems of alcoholism and adverse health conditions resulting from it. The Medicare program authorized considerable coverage for treatment of alcoholism and medical problems associated with alcoholism. The benefits and services available for such treatment are similar to those available for coverage under Medicare of any medical condition. The Medicare statute does not provide a specific benefit for alcoholism, or any other particular diagnosis; services are covered, however, because they are medically necessary and available in a covered setting.

By statute, Medicare is primarily oriented toward covering acute conditions. Thus, the coverage of alcohol treatment is similarly focused. Coverage for alcohol treatment is available in both general and psychiatric hospitals. Based on accepted medical practices, we have established guidelines for evaluating the types and duration of treatment received by Medicare patients. These guidelines are provided to our contractors to apply as they monitor patient care. For example, in the course of treating a beneficiary for alcoholism, a hospital could provide 2–5 days of detoxification. Also, it is possible that treatment will involve a combination of detoxification and rehabilitation. In such cases, up to 3 weeks of care may be necessary. These timeframes provide an illustration of what is typically covered. Depending on medical necessity in the individual case, either less or more care may be covered.

Outpatient hospital services are available to Medicare beneficiaries. As such, outpatient hospital services can be provided in the course of alcohol treatment. These services must be provided by a physician or incident to a physician's services. In other outpatient settings, such as freestanding alcohol treatment facilities, physician services and services which are an integral part of a physician's course of treatment may also be covered.

It is important to note that alcoholism services covered under Medicare must be reasonable and necessary for either the diagnosis or treatment of the patient's condition. This is a general program requirement that applies to all services provided under Medicare. Furthermore, accepted national and international medical references have classified alcoholism as a mental disorder. Therefore, the limitations that apply under Medicare to the use of mental health services have been applied also to alcohol treatment. These restrictions include a limit of 190 days on the lifetime number of days of coverage available for inpatient care in a psychiatric institution. Also, coverage is permitted only for care that represents "active treatment". Finally, physician services for treatment of a mental disorder, provided to an individual who is not an inpatient of a hospital, are subject to a $250 annual payment limit.

HCFA continually reviews its policies and coverage guidelines to ensure cost-effective delivery of services. The issue of alcohol treatment coverage is particularly complex given that alcoholism in the elderly population is a serious problem; there are conflicting views regarding appropriate treatment methods; and treatment can be very expensive. When potential problems with coverage guidelines or the provision of services are identified, HCFA attempts to review and resolve them.

For example, increased awareness regarding treatment methods and questions raised by our contractors related to our alcoholism coverage guidelines have prompted us to clarify them. Revisions to these guidelines are currently in the final stages of review. The Alcohol, Drug Abuse, and Mental Health Administration, with which we have worked closely, has approved our changes. As we have developed these modifications, we have been careful to assure that effective, necessary alcoholism treatment methods will be covered in the most appropriate setting available. These benefits are potentially available to 29 million beneficiaries. It is only reasonable, therefore, that we maximize efficiency in their delivery, while assuring that all legitimate needs are met.

The revised guidelines specify more clearly when inpatient hospital alcohol rehabilitation is appropriate. Also, these guidelines describe the coverage available in settings other than the inpatient hospital setting. For example, guidelines for the coverage of alcohol treatment services furnished to outpatients of a hospital are expanded. This revision will make clear that Medicare payments are available for outpatient hospital services for alcohol treatment. This should foster greater efficiency in service delivery.

I would like to comment briefly on the issue of how much Medicare funding is devoted to reimbursement for alcohol treatment. It is very difficult to determine the level of Medicare expenditures for conditions related to alcoholism. Data related to the types of services provided in non-institutional settings, such as physician services, are not available. Also, we cannot identify, with certainty, all conditions or diagnoses which result from alcoholism. A particular problem is whether the reporting of conditions related to alcoholism is accurate. Undoubtedly, the social stigma associated with such a diagnosis adversely impacts the accuracy of reporting. We certainly sympathize, however, with the need for patient privacy in such reporting.

Several years ago we did try to determine, within these constraints, how much Medicare reimburses for alcoholism conditions. Our estimate included only diagnoses directly related to alcoholism. In fiscal year 1979 dollars, these diagnoses accounted for approximately $90 million in expenditures for institutional care alone. If we inflate the fiscal year 1979 figure based on Medicare expenditure increases, the comparable fiscal year 1982 expenditure level equals $150 million.

We expect that this estimate is low. If the cost to provide treatment in non-institutional settings were included and the cost of treating alcohol related conditions were considered, the total cost of treating alcoholism would likely be considerably higher.

As with other care provided to Medicare beneficiaries, we have mechanisms to monitor alcohol services. Contractors review services, based on our guidelines, to ensure that utilization is not excessive and that treatment methods are medically appropriate.

Finally, I would like to discuss a major demonstration project which we have underway related to alcoholism. This four-year study is a jointly funded project involving HCFA and the National Institute on Alcohol Abuse and Alcoholism. The project was initiated in September of last year. It will enable us to determine the feasibility and effectiveness of providing alcohol services under Medicare and Medicaid in a variety of settings.

Demonstrations will be conducted in six States. Approximately 120 settings will be involved. Reimbursement will be provided for alcohol services delivered in certain settings not currently covered. Emphasis will be placed on those non-institutional settings which are potentially less expensive than the traditional institutional ones. We hope to learn about costs of services in these settings compared to costs involved in service delivery by traditional providers, such as hospitals. We also hope to identify the impact of demonstration sites on the utilization of services of traditional providers; that is, will reimbursement to the new providers result in a shift of utilization from inpatient to outpatient facilities? Finally, the project will provide some information on the quality of care provided in alternative settings.

In summary, I would like to emphasize that the Medicare program covers services for alcoholism and conditions related to it similar to the manner in which other necessary services are covered. I will be happy now to answer any questions you may have.

Senator **Durenberger**. Why don't we start with a matter that I touched on in the opening statement.

Does current medicare coverage tend to force patients into hospital-based treatment even though that may not be the most appropriate setting?

Ms. **Feinstein**. I think, when looking at alcoholism treatment, it is important to differentiate between detoxification services and rehabilitation services.

I think there is unanimity among the medical community that detoxification services most appropriately should be provided in an inpatient hospital setting because of the many medical complications which can arise during that course of detoxification.

Rehabilitation, on the other hand, can be provided to beneficiaries in both the inpatient and outpatient settings. We are hopeful that our newly revised guidelines will make it clear to contractors and the medical community that rehabilitation services can more appropriately be treated and covered on an outpatient basis.

Senator **Durenberger**. If I understand your testimony, then, the reimbursement system which we use now in which we in effect treat—let's take detoxification—in the reimbursement is much the way we treat other kinds of reimbursement. It is not a factor in determining where care is given. In other words, is it your testimony that detoxification is always best handled in an inpatient setting?

Ms. **Feinstein**. Yes, I believe that's true. Dr. Mayer, do you see that any differently?

Dr. **Mayer**. There are a number of examples, Mr. Chairman, of non-hospital detoxification but with very careful medical supervision which has proven to be satisfactory. But, as in any other disorder, the individual case is going to dictate whether it should be in a 24-hour hospital or not.

As far as the rehabilitation portion of treatment for alcoholism goes, of course just detoxifying someone does nothing to his basic problem. That part of the treatment I think is generally given in a general hospital or psychiatric hospital setting because it's widely understood in the treatment community that that's where it will be reimbursed; also, because there is a widespread belief that the hospital provides 24-hour supervision of the patient which isn't available elsewhere. That's not actually true. In fact, the 24-hour supervision available in many other than general or psychiatric hospital settings is often of better quality and really more truly 24 hour than it is in a general hospital.

So it has been true, I think, that the reimbursement policies have tended to send people to the very high-cost settings for treatment.

Senator **Durenberger**. I wonder, Ms. Feinstein, if you could tell us how the guidelines are going to impact on treatment setting, particularly as it relates to rehabilitation?

Ms. **Feinstein**. Previously our guidelines were rather obtuse. I don't know how our contractors managed to process claims and identify whether services were covered or not. We were virtually silent in the area of rehabilitation and the most appropriate source of treatment. Our revised guidelines address that very specifically and indicate that rehabilitation can be provided on an outpatient basis which is a covered service. Moreover, if the physician believes it needs to be covered on an inpatient basis, the guidelines specify that the physician must indicate two things: (1) That the patient shows a propensity to respond to active treatment, and (2) that it can be documented that there is reason to believe that inpatient rehabilitation services for which the patient has been admitted—and which have not been effective for him in the past—can be expected to be effective during this admission.

So there is much more of a demand on the physician involved to document why they believe this patient will respond to services provided in inpatient settings, and, if not, then the services ought to be rendered on an outpatient basis.

Senator DURENBERGER. There are a number of PSRO's in the country that are dealing with alcoholism treatment. And I believe that they have recently proposed criteria for reviewing inpatient alcohol detoxification and rehabilitation units. Have you had input from some of these PSRO's?

Ms. FEINSTEIN. Yes, we have. The National PSRO Council has recently issued some draft guidelines to all PSRO's regarding the review of alcoholism treatment services. Those are just, as I indicated, guidelines, and the PSRO's are free to accept or reject them or make them more stringent or less stringent. There have been two or three PSRO's which have imposed limits on the number of visits, both on the inpatient and outpatient side. The National PSRO Council did not see fit to incorporate those specific limits in their guidelines but rather left that up to the discretion of individual PSRO's.

Senator DURENBERGER. Have you found that kind of information helpful?

Ms. FEINSTEIN. Well, our guidelines match almost identically with the guidelines issued by the National PSRO Council. I would describe them as "broad" and "instructive," rather than specific limits on the number of times a readmission is necessary or appropriate.

Some of the PSRO's have seen fit to go further than that. In fact, our contractor for some of the alcoholism treatment facilities which are very active in providing chemical aversion therapy has seen fit to conduct medical reviews of all claims of those facilities.

So I guess I would respond by saying that some of the PSRO's and some of the contractors have gone further than the so-called national guidelines in this area.

Senator DURENBERGER. But do you find that helpful? On our behalf you are the reimbursor of inpatient treatment. Do you find that kind of onsite, hands-on patient review and recommendation, and the imposition of individual guidelines helpful to you?

Ms. FEINSTEIN. Very much so. I would point out, though, that the statute pretty much dictates that the practice of medicine is something we should not be intrusive into unduly and that it is very much dependent on the local practice patterns of care. So I would assume that that is why the medical community in both the PSRO's and the contractors in certain parts of the country have seen fit to impose different kinds of limits than one would do in national guidelines.

Senator Durenberger. But it is helpful both to you and to me, I take it, to have them perform that kind of a service.

Ms. Feinstein. Yes.

Senator Durenberger. Where will we get that service if we follow the administration's recommendation to abandon peer review and PSRO's?

Ms. Feinstein. Well, I think currently we have some PSRO's involved in this activity and some not; 38 of the 130 PSRO's are currently involved in reviewing some alcohol detoxification and rehabilitation stays.

As I suggested, our contractor in the California area likewise is reviewing medical necessity of one one-hundredths percent of the claims of certain kinds of alcohol treatment modalities. So it is a responsibility being picked up by our contractors in some areas and by PSRO's in others.

Senator Durenberger. Well, if we abandon the PSRO's is it your recommendation we just go to the intermediaries or your contractors and let them do it?

Ms. Feinstein. Yes.

Senator Durenberger. You feel that we can get that same quality control over utilization of alcoholism treatment from the intermediary?

Ms. Feinstein. I believe we are getting that right now in certain instances among contractors.

Senator Durenberger. What other experience do you have with contractors besides California, or what part of California are you talking about?

Ms. Feinstein. Well, it is the Aetna Marin intermediary which is processing the claims on behalf of the majority of the treatment centers which deal in the area of chemical aversion therapy.

Senator Durenberger. Any others around the country?

Ms. Feinstein. Marty?

Mr. Kappert. We don't have any other specific intermediary as heavily involved in this problem. It happens to center in that area.

Just as with other kinds of medical treatment, and so forth, the intermediary is in a position to respond to the local practice and to develop guidelines for claims review.

Senator Durenberger. I don't want to get too deeply into this, but how is your intermediary better equipped than a peer review process to do the kind of good utilization review that we would all like to see?

Mr. Kappert. Well, I wouldn't testify that they would be superior. We think they can do the job as well, primarily on a consistent basis. I think it is really important to look at the fact that, for example, of the 38 PSRO's doing such review, they are not all as actively involved as the two in California which have been in the forefront of this.

The performance of PSRO's on a national basis has been erratic. I think that's the best way to put it.

Senator Durenberger. Well, I won't explore it any further.

Let me get some information from you on the average cost per treatment. Do we know how many alcoholics are being treated in general hospitals, and how many are being treated in psychiatric hospitals, how many in alcoholism hospitals?

Ms. **Feinstein**. Unfortunately, we do not.

Senator **Durenberger**. Why don't we?

Ms. **Feinstein**. I suppose for at least two reasons: one having to do with privacy of medical records and the kinds of information that are reported; the second having to do with the fact that admissions to general hospitals are not necessarily differentiated that precisely to capture an alcohol-specific or an alcohol-related condition.

Dr. **Young**. Yes. I might add that alcoholism is a condition from which many diagnoses flow. For the individual that has liver disease or gastrointestinal disease, the diagnosis may well come in related to the physical condition that flows from the alcoholism. It may well come in in a different form or format, depending on the site of the service. So it is that type of information that we simply do not gather. It would be difficult to gather it because of privacy considerations.

Senator **Durenberger**. Do you know how many beneficiaries use the benefit?

Ms. **Feinstein**. No.

Senator **Durenberger**. Do you have any kind of a general view as to whether it is used many times by a few people or a few times by many different people?

Ms. **Feinstein**. I don't think we can elaborate on that too much. As Dr. Young points out regarding those who have medical conditions that derive from alcoholism, do you count that as a medical admission, an alcohol admission or a psychiatric admission? It gets very tricky in the recordkeeping area.

Senator **Durenberger**. Let me ask you about the demonstration. I understood your testimony to be that cost and quality of treatment will be emphasized. Are you going to include outcomes in your evaluation? And, if so, how will you measure it?

Ms. **Feinstein**. We will be looking at recidivism rates from our beneficiaries being treated in these alternative treatment sites. In addition, we will be looking at alcoholism counselors, who will be a new provider under these demonstrations, to see what kind of results stem from broadening our coverage in the provider area.

Likewise, we will be looking at utilization shifts from inpatient to outpatient to see how much movement is there and what is the total cost for providing those services in these different treatment sites.

Senator **Durenberger**. Will you be looking at different reimbursement methods during the course of the demonstration?

Ms. **Feinstein**. Yes. In fact, one of the six States wishes to begin the demonstration by being paid on a prospective basis; and the other five have evidenced some interest, maybe in the second or third year, in seeing if they can devise a methodology by which they can be reimbursed prospectively for some of the alcoholism rehabilitation services.

Senator **Durenberger**. Which is the State that is interested in prospective payments?

Ms. **Feinstein**. Illinois.

Senator **Durenberger**. Do you have any other States that might be interested in doing it? Are you limited to six? Is that all you think you can afford?

Ms. **Feinstein**. There are six involved in the demonstration. Yes. And I think that the other five are probably interested in doing it on a prospective basis but a little cautious about the method by which they would do prospective reimbursement for these kinds of services.

Senator **Durenberger**. Dr. Mayer, in the recent hearing before the House Subcommittee on Health and the Environment you stated "For the great majority with the disease of alcoholism, it's probably not necessary to treat them in the exceedingly costly general hospital setting. Treatment which is community-based is more reality oriented, more reasonable, and more efficacious."

I wonder if you would briefly explain the premise on which you built that conclusion and what changes you might recommend in medicare policy to accomplish the ends that you have suggested?

Dr. **Mayer**. Yes, sir. I have reached that conclusion both in conference with a great many other people in the alcoholism treatment field and in my own professional experience, treating several thousand alcoholics in an inpatient setting.

I should preface my statements about this by saying that I believe, at the outset of treatment in particular but throughout treatment to a lesser degree, there should be very careful medical supervision of the patient's welfare, because people with this disease frequently do have intercurrent and related disorders and they need to be watched for and addressed when they come up.

For the most part, however, following detoxification in those cases where that is necessary, an active alcoholism treatment program requires the ambulatory and active all-day-long participation of the patient in his recovery process.

My problem with the acute general hospital is that while there is some departure from the old traditional way of putting a patient to bed and not letting him ask any questions and "we take care of you"; still, that feeling about being a patient in a general hospital is dominant, and that is not a helpful or useful or therapeutic psychological environment in which to treat the alcoholic. He has got to participate.

So, while I have run treatment programs that were general-hospital based, in both major experiences I have had covering about 8 years in total in treating alcoholics in a general-hospital based setting, the actual environment was a different cost center within the hospital. It was run totally differently from the rest of the hospital, except that it met accreditation standards. And I feel, as I said before the House Subcommittee on Health and the Environment, that is more reality oriented. The patient isn't going to get better because we do something magical to him. It is true, we can help him; but, unlike the broken bone which we can actually help to mend, unlike the surgical procedure where we take something out that is hurting, in the case of alcoholism the individual suffers from a disease that affects all aspects of his life, and he needs medical attention but along with that he needs a great deal of psychological intervention and social interactive intervention. He has got to be reintroduced to the realities of the problem that he's got, particularly in a society like ours which on the one hand encourages and extols the use of alcohol and on the other hand is very condemning if the alcohol gets the upper hand, which it does in probably 10 percent of all people who drink.

So I have no brief against the general hospital, unless the general hospital creates the kind of dependent helplessness in the patient by the way they treat him, in which case I would have a great deal of problem with it.

Most other than hospital-based treatment programs—and we have many good hospital-based programs, I have to conclude—don't treat the patient as a helpless, dependent person that something is going to be done for; they get his active participation.

As a State health commissioner and a mental health commissioner before that and now in the Federal Government, I am acutely aware that there is an absolute limit at some point on our resources with which to deliver treatment to people.

And to give treatment that is not warranted, from the standpoint of the medical or surgical needs of a patient following detoxification, and to give that at $300-400 a day rate when you can give exactly as good and sometimes far better treatment, particularly using alcoholism counselors along with your professional personnel, in a setting that may cost a fourth that much, just doesn't make sense.

I don't want to be seen as the enemy of the hospital, but for most alcoholics following the initial acute phase, if there is one, of their illness, I believe that the best treatment is given in nonhospital settings.

I would like to add just one other thing, and it harks back to what I said earlier about supervision on a 24-hour care basis.

I do think that for the majority of alcoholics who are really well into the disease to the point where it is interfering with some important aspect of their lives that 24-hour care is by far the most effective and likely to be the most successful approach to treatment.

I also believe that 24-hour care should last probably not less than 4 weeks and, ideally, a little longer. Now, if it is only costing a fourth as much per day, you can afford to give that kind of treatment. I see that as a long-term cost saving of enormous dimensions. Alcoholism is clearly a progressive disease which follows a predictable course—of different speeds, but still a predictable downhill course. If I am treated, or just partially treated, or just readmitted for repeated detoxes with no real addressing of the basic problem, we are going to be faced as a society with far more costly care, even just of the late stages of alcoholism, even if that patient doesn't also develop the terribly costly liver disease and myocardial disease and gastrointestinal disease which are so commonly evident in the late phases of alcoholism.

Senator DURENBERGER. We are clearly entering a period of time in which we will have to deal with the notion of better allocation of resources. And that is not only financial resources, it is also human resources, the skills that we have accumulated in our society, our knowledge, and so forth.

For every dollar we spend on new technology or new treatment we are taking something away from a service that is equally important, such as housing, or food, or a job.

It seems to me we are getting to the point in this country where we are starting to make trade-offs that may not be appropriate.

I am curious to know whether, with regard to alcoholism treatment, there are current shortages in this country—shortages of professionals skilled in diagnosis and treatment or shortages of appropriate treatment settings—which hinder us from delivering services in the most effective manner when dollars are scarce, we have to make sure they're being well spent.

Dr. **Mayer**. Well, you are quite right. We are reaching a point in our society where we are inadvertently making social choices between health care and agriculture and other kinds of human welfare needs, inadvertently making the choices partly because of the fantastic, explosive growth of high-tech, especially health care services.

One of the things that is so attractive about the treatment of alcoholism, in addition to the fact that the patients get better, is the fact that it is probably, in fact in my mind unquestionably, the greatest bargain in medicine today. And there is a tremendous shortage of adequate treatment facilities, which is not to say necessarily a shortage of very expensive high-cost facilities; but there is a shortage of facilities vis-a-vis the magnitude of this public health problem which may be the most important of all of our public health problems.

There are estimated to be 10–12 million untreated, getting worse, alcoholics amongst us in our population today. And they are predictably going to be costly in social terms as well as health care terms as time goes on.

It is possible to render very excellent treatment to them, incorporating both standard medical techniques and judgments with respect to level of care, length of treatment, and so on. It is possible to do that by using a large number of people who in the past have not been part of the treatment system, that is by employing this new category of allied health-care persons that we call "Certified Alcoholism Counselors." They are far less costly in their employment needs and their salaries than are the very highly trained physicians, nurses, and technicians that we use in general hospital care.

Now, one of the problems, one of the reasons there is a shortage both of facilities and of people, is that alcoholism, let's face it, is not altogether a respectable disease. And it's only the tremendous advances in our research in recent years that has given us real assurance that the disease is not a psychiatric disorder. I admit it is listed both in the international nomenclature and in the one that we use in this country under the general heading of "Psychiatric Diseases," but a look at history shows that that is partly because until not very long ago it wasn't even considered a disease at all; it was considered misbehavior, and some kind of moral decay, or degeneracy, or weakness of will. And it's abundantly clear, partly from the large number of recovering alcoholics who have become publicly known and who have gotten their disease under control and have lived exemplary and very productive lives, it's becoming increasingly known that it is not a characterological or a psychiatric disorder; which is not to say it doesn't cause psychiatric problems, not to say that it doesn't require great strength of character to manage this like any other chronic disease.

Senator DURENBERGER. I'm curious to know whether or not we need several more years of demonstrations in a half a dozen States to tell us some of the things that you may already know about either the shortage of treatment facilities or how we deal in a better way with what we have today.

Dr. MAYER. Right.

Senator DURENBERGER. And also, you talked about the value of medical judgment. I am a little concerned by the fact that HCFA seems to think that insurance intermediaries in this country can do a better job of utilization review than can health professionals involved in providing care.

Dr. MAYER. Well, the reason I was waxing on about the unrespectability of the disease and the recency of its acceptance as a disease was to explain that there is a very large shortage of people with adequate training in the field of alcoholism, including psychiatrists and other physicians.

So I certainly couldn't sit in judgment and say Aetna with its medical consultants can do a better peer review job than a PSRO. But in many places a PSRO is bound to be composed of individuals who, while they may be very fine physicians, are still way behind in any understanding of this particular condition as a disease. So while that is changing—about half the medical schools in the country are now beginning seriously to teach about this disease—it is only very, very recently that that has taken place.

So, in one sense, it is probably very desirable that we go on with this HCFA/ADAMHA demonstration to prove what we think we already know; but it's got to be proven to the satisfaction of you and other third party payors who have the responsibility to distribute the funds.

Most of us who have been very much involved in the treatment of alcoholism believe what we are going to be able to show in this demonstration is that it is possible to give a very high level of care with equal success in other than general hospitals and psychiatric hospitals at far less cost to the public as a whole, and therefore better distribute the limited funds that you spoke of.

Senator DURENBERGER. Some people have suggested a nationwide network of licensed outpatient alcoholism treatment centers to help fill the void of adequate facilities you were talking about earlier.

Do you see any particular benefit to that suggestion?

Dr. MAYER. Benefit to nationwide chains?

Senator DURENBERGER. To the networking of licensed treatment centers. in a way that gets information to people about the existence of the facilities and the capabilities of the facilities.

Dr. MAYER. Oh, I see a great deal of benefit to that, indeed. In fact, I think one of our major roles in ADAMHA, in addition to the research that we are supporting and conducting, is exactly the kind of networking that I think you are talking about, in which we can communicate among treatment facilities, encourage the development of other treatment facilities, share the successes and the technique that are the most valuable, support in general this growing part of the health care field and at the same time keep enough tabs on it to guard against its being exploited and becoming a revolving door, sobering up system that used to prevail.

Senator **Durenberger**. Ms. Feinstein, do you want to add anything?

Ms. **Feinstein**. Just that we, too, are very much looking forward to the results of this demonstration. I think prudence dictates that we move slowly and make sure that we are not merely adding a supplementary cost, as you indicated in your opening remarks. And I think that our interests parallel the interests of NIAAA and if the results are in any way what they expect them to be that we would be back before this committee proposing legislative change in that area.

Senator **Durenberger**. I thank you very much, all of you, for your testimony.

Thank you.

Senator **Durenberger**. Our next witness will be the Honorable Wilbur D. Mills, chairman, Committee on Public Policy, National Council on Alcoholism, Washington, D.C.

Mr. **Mills**. Good afternoon, Mr. Chairman.

Senator **Durenberger**. Good afternoon, Wilbur. It's certainly great to have you here today. We all appreciate the value of your personal experiences in this area and welcome both your patience and your presence. Thank you.

STATEMENT OF HON. WILBUR D. MILLS, CHAIRMAN, COMMITTEE ON PUBLIC POLICY, NATIONAL COUNCIL ON ALCOHOLISM, INC., WASHINGTON, D.C.

Mr. **Mills**. Thank you very much.

I am honored to be here today to testify on behalf of the National Council on Alcoholism on the subject of financing alcoholism treatment in the medicare program.

I am accompanied by Dr. LeClair Bissell, who is a physician of many years experience in the treatment of alcoholism and who now serves as president of the American Medical Society on Alcoholism.

I want to applaud the subcommittee for holding this important hearing. I want to congratulate you and the great people of your State. I have been in your State, as you know, on some occasions, and I know of no State that has been more enlightened in this field than the State of Minnesota, and you, sir.

Alcoholism and alcohol abuse are virtually the most serious public health problems facing our country today. Its annual impact on American society nears $100 billion in today's dollars per year. Much of these costs represent a multitude of preventable health care costs related to alcoholism and alcohol abuse.

I have included in my prepared statement, which I am offering for the record, some findings on the seriousness of alcoholism problems among the elderly. I would like to proceed to offer several observations about alcoholism treatment and future policy, if I may.

Alcoholism treatment works. Recovery rates from 60–85 percent are not uncommon in qualified and quality alcoholism treatment programs throughout the country.

The alcoholism treatment system in this country today is diverse. Treatment occurs in a number of settings ranging from acute care and psychiatric hospitals to freestanding programs, halfway and quarterway houses, and even outpatient programs.

As with other diseases, alcoholism treatment consists of several essential services comprising a continuum of care. Single components of this continuum on their own usually do not represent adequate or appropriate treatment for this disease. It is important that Federal policy on reimbursement reflect this fact.

Treatment for alcoholism makes good fiscal sense, in my opinion. It has been shown to reduce significantly the utilization of higher cost health care not only by the alcoholic but also by his or her family.

I have reviewed the current policy on alcoholism treatment under medicare, and I am surprised to find that, although our knowledge of both treatment and the population served has improved so dramatically, our approach to reimbursement remains fundamentally unchanged since 1965.

Let me just add parenthetically here. Had I known as much about alcoholism in 1965 as I learned in 1975, I wouldn't be here today, and these problems probably would have been solved in the initial act.

In my opinion, the policy is flawed by its inflexibility, by the limitation of reimbursement of inpatient services to higher cost settings, and by unrealistic and low limits on outpatient care.

Experience has shown that 24-hour medically supervised treatment in a residential setting for as long as 4 or 5 weeks offers the greatest potential for success for many victims of the disease. Though excellent treatment is provided in acute care and psychiatric hospitals, it is not necessary that rehabilitation treatment be restricted to those settings nor that it routinely occur there. The fact that a greater variety of providers are not serving our medical beneficiaries is the result not of patient needs, which are very diverse, nor of the providers themselves, but rather of the policies which have failed to recognize the potential for effectiveness and cost savings in freestanding settings.

Hospitalization in an acute care setting will frequently be necessary, as was pointed out earlier, for detoxification. The second phase of treatment, which is rehabilitation, can be accomplished in a variety of additional settings.

The National Council on Alcoholism has recently formed a special committee to study the very specific issues in the financing of alcoholism treatment. I happen to be a member of that committee. Together with others representing a range of providers and consumers of alcoholism treatment, we will strive to assemble the best knowledge in the field of treatment and financing and to reach a consensus on reimbursement policy—how soon, I am not yet aware.

I have consulted with the members of the committee in preparation for today's hearings, and convey the following policy recommendations for your consideration:

One, extension of eligibility for participation in Medicare to state accredited freestanding alcoholism treatment facilities. Merely increasing access to hospital services is not the answer to the problem of trying to do more with less for our Nation's elderly and disabled who suffer from alcoholism.

Two, recognition of certified alcoholism counselors as qualified providers of care for both inpatient and outpatient service.

Three, continued availability of medically supervised detoxification in a hospital if indicated.

Four, reenactment of amendments to extend eligibility for alcohol detoxification furnished by accredited nonhospital facilities which were approved by the 96th Congress.

This was an important initiative for cost savings, in my opinion, and should be reintroduced as part of a broader policy to establish reimbursement eligibility for subacute care levels of alcoholism rehabilitation services as well.

Five, expansion of outpatient benefits provided by other than hospital facilities.

I know that the subcommittee has given some consideration to placing limits on inpatient reimbursements under the current alcoholism treatment policy. The National Council on Alcoholism will oppose any effort to decrease the intensity or duration of the acute level of care without extension of eligibility to subacute care levels such as freestanding residential programs, halfway houses, and outpatient facilities.

We will also oppose the placing of limits on hospital benefits which don't take into consideration the needs of the patient. And we will oppose a policy which limits reimbursement to a single component of care such as detoxification. There are countless examples of the ineffectiveness of detoxification as the sole means of treatment for alcoholism. I know of instances in which people have been detoxed 30 to 40 times in one year. That's a great cost, and still they keep going back. They go in and out of a hopelessly revolving door of inappropriate treatment, actually.

I believe that the Federal Government has several other areas of critical responsibility:

One, encouraging the establishment of guidelines for the utilization of the variety of treatment modalities and levels of care.

Two, assuring the continuation of some kind of peer review system in which physicians and qualified alcoholism treatment professionals review the practices, procedures, and results of alcoholism treatment which is reimbursed under the medicare program. I think that's most important.

Three, assuring that treatment methods used in facilities participating in the medicare program are proven to be safe and effective.

Four, continuing to stimulate research into effective treatment techniques and cost-effective methods of delivery.

Five, assuring the continuing role of the National Institute on Alcohol Abuse and Alcoholism in issues pertaining to treatment.

In summary, Mr. Chairman, our Federal policy on alcoholism treatment needs to be modernized. I have talked with people all over the country, including our treatment providers, who share your concern for cost savings, as well as mine. But if our goal is to reduce the costs associated with health care, let us not penalize the patients by limiting their access to care; but, rather, let us encourage providers to move in the direction of less costly forms of care which have been shown to be effective and at the same time provide our beneficiaries and their physicians with some freedom of choice in the selection of alcoholism treatment. It is this opportunity that is before you now, and the National Council on Alcoholism as well as the American Medical Society on Alcoholism stand ready to be of assistance to you.

I thank you for permitting me to make this formal statement.

[The prepared statement of Hon. Wilbur D. Mills follows:]

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Executive Director

STATEMENT OF

HON. WILBUR D. MILLS

on behalf of the

NATIONAL COUNCIL ON ALCOHOLISM, INC.

before the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

U.S. SENATE

"Reimbursement of Alcoholism Treatment Under Medicare"

July 27, 1982

Good afternoon, Mr. Chairman, and members of the Subcommittee. I am honored to have been asked to testify today on behalf of the National Council on Alcoholism on the subject of the financing of alcoholism treatment in the Medicare program. I am accompanied by Dr. LeClaire Bissell, a physician with many years of experience in the treatment of alcoholism, who now serves as President of the American Medical Society on Alcoholism.

I applaud the Subcommittee for holding this important hearing. Alcoholism and alcohol abuse are virtually the most serious public health problems facing our country today. Its annual impact on American society nears $100 billion in today's dollars. And much of these costs represent a multitude of preventable health care costs related to alcoholism and alcohol abuse.

Problems of alcoholism and alcohol abuse among our nation's elderly are serious. I served as Chairman of the National Council on Alcoholism's panel on alcoholism and aging. We found that from 7 to 15% of the older population are experiencing serious health problems as a result of alcoholism and alcohol abuse. It has been reported to me that in some nursing homes the incidence of alcoholism is as high as 4 out of 10 people.

Alcoholics and alcohol abusers of all ages are frequent users of the health care system for illnesses or accidents related to alcohol consumption. And, although alcoholism is often misdiagnosed, it has been shown to be among the 25 most frequent diagnoses for Medicare beneficiaries discharged from short stay hospitals.

On the positive side, our commission found that many older alcoholics respond to treatment better than their younger counterparts. So there is much promise, in a number of respects, in making treatment available to this important part of our society.

I would like to offer several observations about alcoholism treatment:

-- Alcoholism treatment works. This is a well documented fact. Recovery rates of from 60-85% are not uncommon in quality alcoholism treatment programs throughout this country, whether they be free-standing or hospital based.

-- The alcoholism treatment system in this country today is diverse. Treatment occurs in a number of settings, ranging from acute care and psychiatric hospitals, to free-standing programs, halfway and quarterway houses, and outpatient programs.

-- As with other diseases, alcoholism treatment consists of several essential services comprising a continuum of care. These services include physical and psychosocial evaluation, detoxification, counseling, education, and aftercare, including participation in Alcoholics Anonymous.

  The length and type of treatment varies depending on the stage of the illness and the degree of physical and mental impairment of the individual. Single components of this continuum on their own usually do not represent adequate or appropriate treatment for this disease. It is important that Federal policy on reimbursement reflect this fact.

-- Treatment for alcoholism makes good fiscal sense. The American Hospital Association estimates that as many as one-half of the hospital beds in this country are filled with people with alcohol-related illnesses. Thus, it should come as no surprise to you that alcoholism treatment has been shown to reduce significantly the utilization of higher cost health care not only by the alcoholic, but also by his or her family.

Mr. Chairman, I have reviewed the current policy on alcoholism treatment under Medicare, and I was surprised to find that, although our knowledge of both treatment and the population served has improved so dramatically, our approach to reimbursement remains fundamentally unchanged since 1965. I think that poses some significant problems in facing the challenge of providing a needed health service with very real limits on fiscal resources.

In my opinion, the alcoholism treatment policy is flawed by its inflexibility, by the limitation of reimbursement of inpatient services to higher cost settings, and by unrealistic and low limits on outpatient care.

Experience of the last 10 years has shown that 24-hour medically supervised treatment in a residential setting, for as long as four or five weeks, offers the greatest potential for success for many victims of this disease. But though excellent treatment is provided in acute care and psychiatric hospitals, it is not necessary that rehabilitation treatment be restricted to those settings, nor that it routinely occur there. The fact that a greater variety of providers are not serving our Medicare beneficiaries is the result not of patient needs, which are very diverse, nor of the providers themselves, but rather of the policies which have failed to recognize the potential for effectiveness and cost savings in free standing settings.

Hospitalization in an acute care setting will frequently be necessary for detoxification. The second phase of treatment, which is rehabilitation, can be accomplished in a variety of additional settings, such as free-standing alcoholism treatment programs, halfway houses and outpatient facilities.

The National Council on Alcoholism has recently appointed a special committee to study the very specific issues in the financing of alcoholism treatment, largely in response to concerns that you and others have expressed on treatment reimbursement policy. I am a members of that committee. Together with others representing a range of providers and consumers of alcoholism treatment, we will strive to assemble the best knowledge in the fields of treatment and financing. Our goal is to reach a consensus on policy for treatment reimbursement, which I will personally provide to you and members of the Subcommittee upon its completion.

But I have consulted with the members of the committee in preparation for today's hearings, and convey the following policy recommendations to you:

1. Extension of eligibility for participation in Medicare to State accredited free-standing alcoholism treatment facilities, offering 24-hour residential care, a program of active treatment, access to hospital care, and services provided by qualified medical and professional staff.

   Merely increasing access to hospital services in traditional medical and psychiatric settings is not the answer to the problem of trying to do more with less for our nation's elderly and dissabled who suffer from alcoholism.

2. Recognition of "Certified Alcoholism Counselors", working in approved treatment facilities and in conjunction with a medical staff, as qualified providers of care for both inpatient and outpatient services.

   The services of these counselors are critical to the success of treatment, and are probably the "best buy" in health care today.

3. Continued availability of medically supervised detoxification in a hospital if indicated.

   Acute intoxication and severe withdrawal from alcohol or drugs can be a life-threatening situation.

4. Re-enactment of amendments to extend eligibility for alcohol detoxification furnished by accreditated non-hospital facilities which were approved by the 96th Congress.

   This was an important initiative for cost savings, and should be re-introduced as part of a broader policy to establish reimbursement eligibility for sub-acute care levels of alcoholism rehabilitation services as well.

5. Expansion of outpatient benefits provided by other than hospital facilities.

   The current limits of the psychiatric benefit under medicare are unrealistic for alcoholism treatment. National data shows us that the largest portion of patients participating in treatment for alcoholism do so on an outpatient basis. This should have important implications for Federal policy, as well as the potential for cost savings.

I know that the Subcommittee has given some consideration to placing limits on inpatient reimbursement under the current alcoholism treatment policy. The National Council on Alcoholism will oppose any effort to decrease the intensity or duration of the acute level of care without extension of eligibility to sub-acute care levels such as free standing residential programs, halfway houses and outpatient facilities.

We will also oppose the placing of limits on hospital benefits which do not take into consideration the needs of the patient. And, we will oppose a policy which limits reimbursement to a single component of care, such as detoxification. There are countless examples of the ineffectiveness of detoxification as the sole means of treatment for alcoholism. I know of instances in which people have been detoxed 30 or 40 times in one year, at great cost. They go in and out of a hopelessly revolving door of inadequate and inappropriate treatment.

If the goal of your Subcommittee is to reduce costs associated with Medicare, let us not penalize patients by limiting their access to care, but rather let us encourage providers to move in the direction of less costly forms of care which have been shown to be effective. And, at the same time provide our beneficiaries and their physicians with some freedom of choice in the selection of alcoholism treatment.

The question of utilization is one that automatically arises, as it should. What I believe is needed in alcoholism treatment as a tool for both policy-makers and physicians are guidelines for the utilization of the variety of levels of care for alcoholism treatment. These guidelines should not dictate the practice of medicine, but they should assist the physician in determining what level of care is best for the individual, including the appropriate modality, reasonable lengths of stay, and readmissions.

I believe that the Federal government has several other areas of critical responsibility:

1. Assuring the continuation of some kind of peer review system in which physicians and qualified alcoholism treatment professionals review the practices, procedures and results of alcoholism treatment which is reimbursed under the Medicare program.

2. Assuring that treatment methods used in facilities participating in the Medicare program are proven to be safe and effective.

3. Continuing to stimulate research into effective treatment techniques and cost-effective methods of delivery.

4. Assuring the continuing role of the National Institute on Alcohol Abuse and Alcoholism in issues pertaining to treatment.

   NIAAA has played an important role in innovations that have taken place throughout the country with regard to the financing of treatment, as well as in the development of the demonstration project with HCFA as Ms. Feinstein described. The Institute is undertaking a study which will help to promote the credentialling of alcoholism counselors which has important implications for treatment financing. Also, it is about to establish our nation's first national research center on the problems of alcoholism and aging. These projects will contribute greatly to our knowledge of these servious health problems, and to our ability to curtail them in a humane and effective manner.

In summary, Mr. Chairman, our Federal policy on alcoholism treatment needs to be modernized, for the sake of serving people who need these services, and for the reductions in illness and health care costs of our people. I have talked with people all over this country, including treatment providers, who share your concern for efficiency and cost savings. Our challenge is to see that limits on reimbursement policy do not preclude the opportunity for cost savings. I think it is that opportunity that is before you now. As we examine future innovations in the mechanisms for payment, such as prospective payments to providers, or recipient vouchers, we must assure greater flexibility in the benefit, realistic protections against abuse, and the best possible care for our citizens.

Thank you. This concludes my formal statement. Both Dr. Bissell and I will be happy to answer questions that you or members of the Subcommittee wish to bring before us.

Mr. MILLS. If it is possible, Dr. Bissell has a short statement that she would like to make at this time.

Senator DURENBERGER. You may proceed, Doctor.

Dr. BISSELL. All right. Thank you very much.

Before I start my prepared statement, I might volunteer that I was a member of a PSRO in New York which came up with guidelines roughly 4 years ago.

We discovered at that time that alcoholism was the No. 1 admitting diagnosis of the PSRO-delegated hospitals in Manhattan, with drug addiction being the No. 2, and I believe the figures were at about $10 million for the two at that point.

Those are rather good guidelines, by the way.

STATEMENT OF DR. LeCLAIRE BISSELL, PRESIDENT, AMERICAN MEDICAL SOCIETY ON ALCOHOLISM

Dr. BISSELL. For 11 years, from about 1968 to 1979, I was in charge of the Smithers Alcoholism Treatment and Training Center in New York, which was a not-for-profit comprehensive alcoholism treatment facility, administratively part of a Columbia University Teaching Hospital. Then later I was for 2 years head of a freestanding proprietary alcoholism treatment facility in Rhode Island, and my opinions and perceptions of course reflect that background.

Whether or not medicare covers the cost of residential treatment often depends not on what the facility is but on what it is called. In California the word "hospital" is used for a variety of physical structures and settings in which medicare pays for treatment.

Our Smithers Inpatient Rehabilitation Unit is actually housed in a converted mansion on 93d Street in Manhattan. That is the opposite side of town from St. Luke's Roosevelt Hospital. But since it was part of a hospital, it could accept medicare and medicaid patients, and did so at a day rate of about one-third what the hospital charged.

In Rhode Island the facility where I worked was not called a hospital, it was not therefore reimbursed, but in fact was built to physical standards and staffed in such a way as to have met the requirements for most hospitals. So we had that contradiction.

Rhode Island has mandated alcoholism coverage for residential treatment in both freestanding and hospital settings for group health policies sold in the State. This legislation includes coverage for some halfway house services and also for limited outpatient benefits for alcoholics and also their families.

Unfortunately, there are still some very serious gaps. Rhode Island Blue Cross did an excellent job with the media in letting its policyholders know that they had coverage, but the people didn't read the fine print. It didn't occur to them that certain illnesses might be arbitrarily excluded.

It seems bizarre, as well as sometimes tragic, to have to say to a young Federal employee living in Rhode Island that the particular Blue Cross policy approved by a presumably enlightened government agency does not provide coverage, particularly after all of the praises we have given to employee assistance programs.

It is even worse to explain to an elderly retired person who has bought an individual Blue Cross policy, believing that this will cover whatever medicare fails to cover, that alcoholism is excluded from both.

No one enjoys turning away sick people in need of treatment, and, particularly, no one likes to share the shock and despair and surprise of realizing that an assumed coverage doesn't exist.

Alcoholism is a disease characterized by denial. No one plans to have it, and no one plans to have a member of his family have it in the future. There is little sense of obligation to provide coverage for others when their illness is perceived as self-inflicted anyway. Curly-haired tots with braces make for very good posters and easily a correct advocacy; alcoholics do not.

At Smithers Center we did have the experience of offering rehabilitation unit treatment for some years before medicare coverage was granted. We then received the coverage in the late 1970's and could observe the difference. We counted the number of individuals at the age of medicare eligibility before and after that change. We made no particular effort to publicize that a change had occurred or to recruit the new population for treatment.

There was a rapid and quite obvious increase in older people in the treatment population, but that leveled off almost at once and then stayed static at the new level. Speculation that a phalanx of elderly would suddenly arrive in huge numbers to demand treatment services as acknowledged alcoholics was not borne out.

Clearly, the number of people identified as alcoholics and seeking treatment as such in specialized facilities stays limited.

The change in coverage did not result in high utilization by the Federal employees, either—an argument used, oddly enough, to stop their coverage, that was explained as cost containment while at the same time we were told that the benefit was too new and too little utilized to have cost much.

By the same token, I doubt if extending the medicare coverage would produce a great increase in cost, since only a certain population would in fact use the diagnosis and treatment. I do believe it would be more effecient than treating symptoms of alcoholism and treating the patient as if something else were the problem.

Thank you.

Senator **Durenberger**. We will make sure that both of your statements in full are made part of the record.

[Dr. Bissell's prepared statement follows:]

Testimony of

LeCLAIR BISSELL, M.D.
PRESIDENT
AMERICAN MEDICAL SOCIETY ON ALCOHOLISM

Before the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE

"Reimbursement of Alcoholism Treatment Under Medicare"

July 27, 1982

I am LeClair Bissell, M.D., President of the American Medical Society on Alcoholism, a specialty organization of some 1100 physicians. For eleven years, from 1968 to 1979, I was in charge of the Smithers Alcoholism Treatment and Training Center in Manhattan, a not-for-profit comprehensive alcoholism treatment facility which is administratively part of a Columbia University teaching hospital. I then spent two years (1979 - 1981) as head of a freestanding proprietary alcoholism treatment facility in Rhode Island. My opinions and perceptions will reflect that background.

Whether or not Medicare covers the cost of residential treatment often depends not on what the facility is but on what it is called. In California the word "hospital" is used for a variety of physical structures and settings in which medicare pays for treatment. Our Smithers inpatient rehabilitation unit is actually housed in a converted mansion on the other side of Manhattan, but as part of St. Lukes/Roosevelt Hospital it could accept both Medicare and Medicaid patients and does so at a day rate roughly one-third that of the general hospital rate. In Rhode Island the facility where I worked was not called a hospital, it was licensed, instead, as a freestanding "alcoholism treatment facility," and is therefore not eligible for Medicare, yet is built and staffed to specifications that would meet the licensing requirments of many modern hospitals.

Rhode Island has mandated alcoholism coverage for residential treatment in both freestanding and hospital settings for group health policies sold in the state. This legislation includes coverage for some halfway house services and also for limited out-patient benefits both for alcoholics and their families.

Unfortunately serious gaps remain. Rhode Island Blue Cross has done a good job with the media in letting its policy holders know that they have coverage. People don't usually read fine print. It doesn't occur to them that certain illnesses may be arbitrarily excluded. It seems bizarre as well as sometimes tragic to have to say to a young federal employee living in Rhode Island that the particular Blue Cross policy approved by a presumably enlightened federal agency does not provide coverage, particularly after all of the praises we have given to employee assistance programs. It is even worse to explain to an elderly retired person who has bought an individual Blue Cross policy believing that this will cover whatever Medicare does not that alcoholism is excluded from both. No one wants to turn away sick people in need of treatment. No one wants to share the shock and despair of realizing that an assumed coverage doesn't exist.

Alcoholism is a disease characterized by denial. No one plans to have it or for a member of one's own nuclear family to have it in the future. There is little sense of obligation to provide coverage for others when their illness is perceived as self-inflicted anyway. Curly-haired tots with braces make for good posters and easily attract advocacy. Alcoholics do not.

At Smithers Center we had the experience of offering rehabilitation unit treatment for some years before Medicare coverage was granted. We received it in the late 1970's and could observe the difference. We counted the number of individuals at age of Medicare eligibility before and after the change. We made no particular effort to publicize that a change had occurred nor to recruit this population for treatment. There was a rapid and quite obvious increase in older people in the treatment population, but this leveled off almost at once and then remained static at the new level. Speculation that a phalynx of elderly would suddenly arrive in huge numbers to demand treatment services as acknowledged alcoholics was not borne out. Clearly the number of people identified as alcoholics and seeking treatment in specialized alcoholism facilities remains limited. A change in coverage did not result in high utilization by the federal employees either, an agrument used, oddly enough, to stop their coverage that was explained as cost-containment while at the same time we were told that the benifit had been too new and too little utilized to have cost much. By the same token, I doubt if extended Medicare coverage would produce any great increases in cost since only a certain population would use the diagnosis and treatment offered. I do believe that for those that do utilize the benefit, alcoholism treatment is more likely to lead to lasting recovery and will cost much less for the individual involved than does the alternative system of pretending the problem is really something else or treating the symptom rather than the underlying cause.

So much for insurance. I have been asked about different treatment needs for different age groups. There are differences. Elderly people are more likely to perceive alcoholism as a weakness or moral failing rather than as an illness. When they do realize that they are sick rather than bad, they often subscribe to the old mental health model that regards alcoholism as symptomatic of an underlying emotional problem. To be alcoholic then is to be crazy, to need a mental hospital, to submit to treatment by a psychiatrist. Older people were not raised knowing that alcoholism is best approached as the primary illness which in fact it is. One therefore has a problem of redefinition of what the problem really is before appropriate care can be sought and accepted.

Another problem is that the temporary (and sometimes permanent) brain damage caused by alcohol can mimic senility. It takes time away from alcohol and other drugs before a patient's thinking clears and the direction and degree of change and recovery become apparent. This may take a lot longer for an older person who may therefore need more treatment time than a younger one. Days may elapse before certain patients are able to remember anything useful from treatment at all. Five days of in-hospital detoxification may well take care of any physical danger from alcohol withdrawal, but won't do much for long-term recovery in a patient not yet able to retain most of what's being said.

Older people are more likely to have other physical limitations that interfere with treatment. These additonal problems have often put them in regular contact with well-meaning physicians whose training in alcoholism is limited. Accordingly there is an excellent chance that one or more of them has misread the situation and prescribed other mood-changing drugs which themselves cause physical dependency and delay the course of recovery. Both physical and psychological withdrawal take much longer when one is dealing with a combined drug problem rather than alcohol alone. Many old people stumble, fall and break hips, not because they're clumsy, but because they're drugged. Many are not forgetful and confused because they're senile, but because they are overdosed with tranquilizers. The drugs they use are legal; the pushers are physicians.

Other problems arise from the social realities faced by older people in our society. As you know, some 75% of those below poverty level are elderly white women. Poverty, physical disability, fear of being out alone or facing strangers, many of whom truly do not welcome elderly people, add barriers.

To get a young person to an AA meeting requires overcoming fears of stigma and shame but doesn't pose the same questions of how to pay for a bus, drive a car or get safely down a poorly lighted block at night. There are many resident hotels in New York where to leave one's room at certain hours means the risk of a hallway mugging or the relative certainty of a burglery. If one's only remaining treasures are a television set and an aging dog or cat, who will stay home to protect them?

There are problems that do not resolve easily, but they can be addressed. Elderly people can and do respond to treatment. They do recover.

In closing, I'd like to tell you of a letter received from a former Smithers patient when she returned a routine follow-up questionnaire. We asked what she had liked most about Smithers, what she liked least about it and what she thought we most needed to change. She replied that the most valuable single experience for her was seeing the symptoms of alcoholism listed on a blackboard, to realize that these things had been happening to her though she had kept them secret. She went on to say, "It was such a relief to find I was just alcoholic. At seventy-seven, I was afraid I was getting old." She then went on to describe a new life of yoga lessons, AA meetings and renewed contacts with friends and family. Medicare made her treatment at Smithers possible. I'm sorry that she and others like her are not here today to testify for themselves.

Senator **Durenberger**. Wilbur, you are one of the country's more famous alcoholics.

Mr. **Mills**. I took my television crews with me, you know, all the time. [Laughter.]

Senator **Durenberger**. Well, I can't remember the specific date but as I recall it was 1975.

Would you briefly describe for us the nature of your treatment at that time, and maybe generally the nature of treatment that was available in that period of time, and compare that with the kind of alcoholism treatment that is available today?

Mr. **Mills**. I was put in Bethesda Naval Hospital first, in the latter part of November in 1974. I went there not as an alcoholic—I want it clearly understood—the doctor sent me there because I had high blood pressure. I don't know whether my record shows that I was treated for high blood pressure or finally for alcoholism. That is one of the difficulties in getting information about the numbers of alcoholics. I have even known an individual who was listed as being treated for epilepsy because they took him to the hospital in a convulsion, and there is a degree of similarity between the action of the two people.

At any rate, I was there for 60 days. I left, ready to come back to work in 1975, sometime around the 1st of February. But I wasn't an alcoholic. And I had to convince this incompetent doctor, who is now my good friend, but I hated him then, a lieutenant commander in the Navy—I swore he would never get to be a captain, but he is a captain, and of course he got to be a captain because he properly diagnosed me; I think I made a contribution to his promotion.

At any rate, I had to convince them, and I went out then to show them I could drink again without getting drunk; and, of course, I got drunk. It is a very progressive disease. I can attest to that. I took one drink; I had to have another one. I took two bottles, 2 quarts, of 100-proof vodka during the course of the evening and went to New York and had a lot more during the night. They found me up there and brought me back to the same hospital the next day. I was there for about 10 days.

I went off to Florida. Here in Washington in February they wanted to send me to your State, or to Toronto, or New York, somewhere, and I told them I didn't want to go any place in the snow if I was sick and had to recover. I wanted to go South. So they found a place in Florida.

Very fortunately, they put me in a very fine place where the doctor considered alcoholism to be a family disease. I guess, Dr. Bissell, he was one of the very first to approach it on that basis. He insisted on my wife coming, and she stayed with me for 6 weeks. I had thought she was going home to get a divorce; she had no such intention. She knew all along what was wrong with me. It was in a very short order that our relationship was improved and we were brought back together. Life between us has been greater than it was even before.

But I left there with this awful feeling about being an alcoholic. Nobody ever considered an alcoholic to be any lower than I did.

I came back here and walked through the National Airport, and I passed one of these cocktail lounges. Immediately the desire to take a drink hit me. And that desire stayed with me until some time up into December. And all of this time I was down on myself because I was an alcoholic. I didn't want to look at you, I didn't want to face anybody. My colleagues were very nice to me, came by every day saying I looked better, which I knew I didn't. But they were pulling for me, saying, "Now, you're going to make it. You're going to make it. You're going to come back," and all of this—very sympathetic and very loving. And I appreciated their attitude more than I can tell you. But I still didn't want to face the world and be an alcoholic.

Then somebody said something to me about it being a disease. I had not ever thought of it as being a disease. I knew it wasn't. I knew it was a failing on my part, lack of character, willpower, or something. I had been raised to believe that.

When I got to the point where I could accept it as a disease, I began to look at myself in the mirror, and I could see something more than just what I thought I was seeing earlier. I began to like myself a little bit.

Do you know, I woke up one morning and I didn't have that desire to take a drink at all. I had been told all of these things in this facility and in the treatment down there. I don't remember too much about the treatment, frankly, I was too foggy mentally to know anything. My mind was badly affected. It was in a fog for a long, long time. It took me months to get back to where I could concentrate, to where I could work a crossword puzzle or anything like that.

The treatment down there has not changed all that much. I have been in a great number of facilities throughout the country and have found a growing feeling among most of the facilities today that this is a family disease. I can't overemphasize the importance of it being a family disease.

I think this is one of the great changes in the whole theory of the treatment of alcoholism: You don't just treat the alcoholic.

I have seen cases of a man who lived with a family and a wife for 30 years, and he gets sober and his wife doesn't know how to live with him; so she divorces him. I don't know why it is, but that happens so often.

I have seen children, and it took them a lot longer to recover from the effect of their father's drinking than it did for the father to recover from the effects of his drinking.

I am convinced it is a family disease, and I'm convinced that the entire family needs some attention. That is not necessarily the case with the older people, of course; but certainly if the man's an alcoholic and the wife's living with him, I think she needs some attention regardless of her age. She can be 80 and need some attention.

These are some of the changes I think that are taking place in the recognition of the need for a different type of treatment and the broadening of the treatment.

But I don't think there is too much change, really, where I went, in the treatment today and the treatment that I received then. I was told that it was a disease; I was told that it was a progressive disease; I was told it was a treatable disease, that if I had the desire to go a day at a time without a drink, in all probability I could, but that my recovery depended upon my desire to recover.

Pardon me for taking so long in answering your question.

Senator **Durenberger**. No, I appreciated that.

I don't know the detail of your involvement. I guess we first met in a dusty county fairground in southern Minnesota——

Mr. **Mills**. Freeborn.

Senator **Durenberger**. Freeborn County, at a freedom fest in the summer of 1977. And I realize you have committed a fair part of your life to helping others discover what you have discovered, which includes not only providing some insight on who has the skills to help people but also dealing with what we might call the economics of dealing with the problem.

Other than these specific recommendations that were included in your opening statement, can you comment on the importance of "cost-sharing" in this process? Is cost-sharing important with respect to giving the individual an incentive to seek out effective care and be successful in using it? Are there some other important ways that we could begin to change the third party reimbursement system?

Mr. **Mills**. It is my understanding that under the insurance program there is a sharing, of course. The patient pays 20 percent, I believe. I think that's our policy, 20 percent of the cost. I don't know if that should be increased or not.

Under medicare the people are now being or have been taxed during their lifetime for the plan A part, and they still continue to pay a monthly payment for plan B. I don't know whether that should be increased; I just haven't gone into it enough. I don't know what the costs are today.

But the main thing is that we include this type of treatment outside of a hospital under medicare, I think. I think that's the real thing that I am saying today. If that means additional cost to the people, I think that people would be perfectly willing to pay it; though I may be wrong about that. When you pass the hat for alcoholism among the public, you get about one thirty-fifth of what you would get if you were passing the hat for some research in heart disease or some research in cancer.

My own opinion is that alcoholism presents more of a medical problem, social and economic, than any other disease. It affects more people than any other disease. And when you add to it all of the people who die of heart attacks that are alcohol induced, and you add to it all of the tragedies that happen on the highways that are not known as alcohol-related but really are, I think undoubtedly more people die of alcoholism and its effects over the course of the year than any other disease. The AMA says it's third, but I think it's first.

If people could come to the point of recognizing that it is a national problem, not just the problem of the drunk but a national problem, not just a medical problem but a social and economic problem, I think people then would be more generous in their giving.

But until we get to that point I think the individual who is involved and whatever insurance program he has, whatever, if it is medicare finally, has to bear the burden.

Senator **Durenberger**. I have a question for either of you, and then I have to let you go and depart for a vote.

Has the Council developed any information that relates to how many alcoholics are treated in what kind of settings, and how many people use medicare benefits, insurance benefits, and so forth?

Mr. **Mills**. The Council has not. Now, let me say this: There is an estimate that I have heard, and I think it probably is low, that there probably are 500,000 alcoholics treated annually in hospitals and other types of standing facilities.

Dr. **Bissell**. That is as "alcoholics."

Mr. **Mills**. As alcoholics, treated as alcoholics, I understand. They may be in the hospital under an entirely different diagnosis, you see. As I indicated earlier, many of the doctors will cover. I have had doctors tell me that they would not tell the leading citizen in their community, even if they knew he was an alcoholic, that he was an alcoholic. They wouldn't dare do it. And I have had interns not yet in the practice tell me that they would not do it if they got it.

So there seems to be a general reluctance to designate everybody who is in a hospital as being "an alcoholic."

Is that right, Dr. Bissell?

Dr. **Bissell**. Yes.

Mr. **Mills**. I have found that to be the case in traveling about. It's the embarrassment, of course, of being an alcoholic. I have often said there is nothing wrong with me as long as I don't take a drink.

Senator **Durenberger**. At the present time we treat everyone in a hospital setting pretty much the same. But once it is clear that alcoholism is the diagnosis and not something else, an alternative to the current reimbursement system becomes much more important.

Mr. **Mills**. I can't understand the feeling of the insurance industry, and I have talked to many of them even before I left Congress, about their reluctance to insure the alcoholic's care in a freestanding facility. They pay a lot more in a hospital, and they are perfectly willing to do that. I am not belittling the hospital; there is a place for it. But I can't understand the people who are paying the cost of the whole thing being satisfied to pay more per day than is necessary to be paid to take care of the patient who is covered by them. I just can't understand that, the reluctance on their part to the fact that it would be much cheaper, they'd get by with a lot less cost, if they would just extend the payment.

Senator **Durenberger**. We are going to have to recess for another vote. Before we do, though, let me just make a suggestion both to you and to Dr. Bissell with regard to the comments that were made earlier about the function of peer review. If on behalf of the Council or individually you might add your thoughts about the appropriateness of peer review as opposed to the use of medicare intermediaries it would be helpful to us and the record.

Let me just thank you, Congressman, for being here.

Mr. **Mills**. Thanks.

Senator **Durenberger**. It's just great to see you.

Dr. Bissell, we appreciate your testimony also.

We will recess the hearing for 5 or 8 minutes, whatever it takes to get back. I apologize to the panel about the delay.

Mr. **Mills**. Thank you very much.

Senator **Durenberger**. Thank you.

[Whereupon, at 3:27 p.m., the hearing was recessed.]

AFTER RECESS

Senator **Durenberger**. Our next witnesses will be a panel consisting of Mr. Orville McElfresh, vice president, program services, Lutheran Center for Substance Abuse, Chicago, Ill., and a board member for the National Association of Alcohol Treatment Programs, Newport Beach, Calif.; Mr. Harold Swift, the administrator of the Hazelden Foundation, Center City, Minn.; and Dr. Eck G. Prud'Homme, the chief of medical staff and chief executive director of the Shick Shadel Hospital, Fort Worth, Tex.

Gentlemen, I thank you for your patience and thank you for being here.

We will start with Mr. McElfresh first.

STATEMENT OF ORVILLE McELFRESH, VICE PRESIDENT, PROGRAM SERVICES, LUTHERAN CENTER FOR SUBSTANCE ABUSE, CHICAGO, ILL., BOARD MEMBER, NATIONAL ASSOCIATION OF ALCOHOL TREATMENT PROGRAMS, NEWPORT BEACH, CALIF.

Mr. **McElfresh**. Good afternoon, Mr. Chairman and members of the committee.

It's an honor and a pleasure to be a part of this hearing today. My name is Orville McElfresh. I am appearing today both in my role as vice president for program services for Lutheran Center for Substance Abuse, a substance abuse specialty hospital in Park Ridge, Ill., just outside Chicago and as a member of the board of directors of the National Association of Alcoholism Treatment Programs.

NAATP, the National Association of Alcoholism Treatment Programs, is a private sector health care association comprised of some 250 facilities throughout the United States. We represent both nonprofit and proprietary providers offering inpatient, outpatient, residential, and hospital-based services.

Our primary concerns are to enlighten the public as to the treatability of the disease of alcoholism, to create more specific standards for alcoholism treatment, and to achieve more adequate reimbursement for appropriate care.

It is of great concern to us that avenues of treatment for the victims of alcoholism be broadened and not diminished. We are committed to the idea of different levels of care for appropriately diagnosed stages of the disease of alcoholism. This is a concept long held and uniquely implemented at the Lutheran Center for Substance Abuse, and I wish to take a few moments to describe our multilevel approach and why we believe it is cost efficient and clinically effective.

Historically, whether alcoholics went to a hospital or a nonhospital facility, they basically received the same level of care. The hospital program obviously cost more than the nonhospital. Since alcoholism is a chronic progressive disease and patients come to treatment in various stages of the progression, with different histories, different symptomatologies, and different needs, we believe that there needs to be a comprehensive level of care system that is both cost effective and clinically effective.

Consequently, the question isn't whether outpatient is as effective as inpatient or whether outpatient is more cost effective than inpatient; the question is which level of care is necessary to meet the patients' clinical needs.

Obviously, outpatient may be just as effective as inpatient providing the person can be treated in an outpatient program, and then it is more cost effective.

Likewise, if the patient needs inpatient, the question isn't whether a freestanding or hospital program is most effective or whether a freestanding is more cost efficient; the question, again, is which level of care is necessary to meet the patients' clinical needs.

Many alcoholics need a hospital program because of serious medical and psychiatric conditions, and some even need intensive care in a general hospital because of the critical concurrent medical and psychiatric conditions.

At the Lutheran General Medical Center we have operational a cost effective, comprehensive level of care system. Criteria for admission to each level have been developed. We should also add that we don't believe age should be a barrier for the kind of treatment a patient needs to receive.

The lowest and most effective level of care in our system is our primary outpatient program. For those who meet the critera, these individuals can remain on their jobs and with their families while being treated in an intensive evening program 4 nights a week, and then 1 night a week for 10 weeks following.

I might also add that the families are involved in a minimum of 2 nights a week in this program.

The second level of care is a lower cost residential nonhospital facility for adults and youth who need an inpatient program but have no significant medical or psychiatric conditions.

The third level of care is a specialty hospital for patients who have alcoholism and/or substance abuse and serious medical and/or psychiatric conditions that require concurrent treatment in a hospital.

Previously, in our alcoholism treatment services and still true, I think, in the alcoholism field in general, patients received treatment for serious medical/psychiatric conditions in a general hospital at a higher cost and then were transferred to an alcoholism treatment program. By providing concurrent treatment, the length of stay can be reduced and treatment can take place in a specialty hospital with lower charges than a general hospital, resulting in a double cost reduction.

The fourth level of care is an intensive medical and psychiatric unit in a general hospital with staff knowledgeable in alcoholism and comfortable with alcoholism patients. This level is for patients with hepatic failure, GI hemorrhaging, cardiac arrythmias, major depressions, certain organic brain syndromes, and paranoid disorders. We always have a number of patients in this level.

It is not necessary to describe here the additional levels of aftercare, the extended youth facility, and independent living programs that we have.

It is important, I think, to underscore that we have learned that in the case of many of the aging alcoholics a tremendous number of complications arise and are in fact exacerbated with the combination of normal ailments common to the elderly and the effects of long-term drinking. These complications and the necessity for a comprehensive capability to deal with them indicate a mandate for continued availability of inpatient care for long-term elderly alcoholics.

If we are to provide an adequate cost-effective system for alcoholism patients and assure their not being treated as second-class citizens, it is important for those in and outside the alcoholism field to recognize this need for cost-effective levels of care and to establish patient criteria for each level.

It is additionally important that trained professionals in the alcoholism field continue to make these diagnostic decisions regarding the appropriate level of care—not the Federal Government, and not the insurance companies.

It is the responsibility of the treatment professional to insure that the alcoholic patient is placed in the level of care appropriate to the needs of the patient in this progressive disease.

Treatment outcome statistics and attendant costs must be evaluated as more than mere numbers. While inpatient, outpatient, and residential care may enjoy similarly positive success rates, we must remember that these various levels of care are tailored and effective for different populations.

Naturally, the more intense the level of care, the higher the price tag; but appropriateness is the key word here. We would not place a patient experiencing alcohol psychosis in an outpatient program, nor would we necessarily place an individual who is simply questioning his or her use of alcohol in an acute care hospital.

The Government's responsibility, we feel, is to insure the continuation of diagnostic and placement capabilities with the professional to whom the care of its beneficiaries is entrusted.

We believe that comprehensive levels of care is the model for the 1980's and the 1990's, and that it needs to be developed into regional areas.

This concludes my oral testimony, Mr. Chairman. I have a longer statement from the Lutheran Center for Substance Abuse which I respectfully request to be a part of the permanent record.

In addition, the subcommittee will receive by mail a formal written statement from the National Association of Alcoholism Treatment Programs, which I also respectfully request to be made a part of the same permanent record.

I appreciate the opportunity to appear before you today, and we would be pleased to answer as many questions as you might have.

Thank you.

Senator DURENBERGER. Thank you. Both those statements will be made a part of the record.

[The prepared statement of Orville McElfresh follows:]

Lutheran Center
for Substance Abuse

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Park Ridge, Illinois 60068

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A SUMMARY OF THE TESTIMONY DELIVERED BEFORE THE SENATE FINANCE SUBCOMMITTEE ON HEALTH

by Orville McElfresh

Representing

Lutheran Center for Substance Abuse

and

National Association of Alcoholism Treatment Programs

July 27, 1982

1. The alcoholism field shares the desire to develop a system of care that is both cost efficient and clinically effective.
2. A comprehensive levels of care system that matches patients' needs with treatment services.
3. The question of whether outpatient treatment is more effective than inpatient services is misdirected. The central question is what level of care is best suited to meet the patient's clinical needs.
4. Lutheran General Medical Center has operational a system of treatment that offers five distinct levels of care.
   a) primary outpatient services
   b) residential non-hospital rehabilitation treatment program
   c) specialty hospital - concurrent treatment of serious medical/psychiatric conditions and alcoholism/substance abuse.
   d) general hospital intensive care for critical medical/psychiatric conditions and alcoholism
   e) aftercare outpatient and residential living programs

   These services are available for adults and youth.

Human Ecology is the understanding and care of human beings as whole persons in light of their relationships to God, themselves, their families and the society in which they live

Good afternoon Mr. Chairman and Members of the Committee. It is an honor and a pleasure to be a part of this hearing today. My name is Orville McElfresh. I am appearing today, both in my role as Vice President, Program Services for Lutheran Center for Substance Abuse, a substance abuse specialty hospital in Park Ridge, Illinois, outside of Chicago, and as a member of the Board of Directors of the National Association of Alcoholism Treatment Programs, the NAATP. NAATP is a private-sector health care association, comprised of some 250 facilities throughout the United States. We represent both non-profit and proprietary providers, offering inpatient, outpatient, residential and hospital-based services. Our primary concerns are to enlighten the public as to the treatability of the disease of alcoholism, to create more specific standards for alcoholism treatment and to achieve more adequate reimbursement for appropriate care. It is of great concern to us that avenues of treatment for the victims of alcoholism be broadened, not diminished. We are committed to the idea of different levels of care for appropriately diagnosed stages of the disease of alcoholism. This is a concept long held and uniquely implemented at Lutheran Center for Substance Abuse and I wish to take just a couple of moments to describe our multi-level approach, and why we believe it is cost efficient and clinically effective.

Historically, whether alcoholics went to a hospital or non-hospital facility, they basically received the same level of care. The hospital program obviously cost more than the non-hospital program. Since alcoholism is a chronic, progressive disease and patients come to treatment at various stages in the progression with different histories, different symptomatology, and different needs, we believe that there needs to be a comprehensive levels of care system that is both cost effective and clinically effective. Consequently, the question isn't whether outpatient is as effective as inpatient or whether outpatient is more cost effective than inpatient. The question is which level of care is necessary to meet the patient's clinical needs. Obviously outpatient may be just as effective as inpatient providing the person can be treated in an outpatient program, and it is then more cost effective than inpatient. Likewise, if the person needs inpatient, the question isn't whether a free standing non-hospital or hospital program is most effecive or whether a free standing facility is more cost efficient. The question again is which level of care is necessary to meet the patient's clinical needs.

Many alcoholics need a hospital program because of serious medical/psychiatric conditions and some even need intensive care in a general hospital because of critical concurrent medical/psychiatric conditions. At the Lutheran General Medical Center we have operational a cost effective, comprehensive levels of care system based on patient need. Criteria for admission to each level have been developed.

The lowest and most cost effective level of care in our system is the Primary Outpatient Program. For those meeting the criteria, they remain on their jobs and in their homes while being involved in an intensive evening program four nights a week for four weeks and then one night a week for ten weeks.

The second level is a lower cost residential non-hospital rehabilitation facility for adults and youth who need an inpatient program but have no significant medical/psychiatric conditions.

The third level is a specialty hospital for patients who have alcoholism/substance abuse and serious medical/psychiatric conditions that require concurrent treatment in a hospital. Previously in our alcoholism treatment services, and still true in the alcoholism treatment field generally, patients received treatment for serious medical/psychiatric conditions in a general hospital at higher cost and then were transferred to an alcoholism inpatient treatment program. By providing concurrent treatment, the length of stay is reduced and the treatment takes place in a specialty hospital with lower charges than a general hospital resulting in a double cost reduction.

The fourth level is an intensive care medical/psychiatric unit in the general hospital with staff knowledgeable in alcoholism and comfortable with alcoholism patients. This level is for patients with hepatic failure, GI hemmorrhaging, cardiac arrythmias, major depressions, certain organic brain syndromes and paranoid disorders. We always have patients in this level of care.

It is not necessary to describe here the other level of care for aftercare such as youth facility, independent living program for adults and halfway house programs.

It is important to understand -- as we have learned -- that in the case of alcoholism among the aging, tremendous complications arise and are, in fact, exacerbated with the combination of normal ailments common to the elderly and the effects of long-term drinking. These complications and the necessity for a comprehensive capability to deal with them, indicate a mandate for continued availability of inpatient care for the long-term, elderly alcoholic.

If we are to provide an adequate cost effective care system for alcoholism patients and assure their not being treated as second class citizens, it is important for those in and outside the alcoholism treatment field to recognize this need for cost effective levels of care and establish patient criteria for each level.

It is additionally important that trained professionals in the alcoholism field continue to make these diagnostic decisions regarding appropriate level of care - not the federal government and not the insurance companies. It is the responsibility of the treatment professional to ensure that the alcoholic patient is placed in the level of care appropriate to the needs of the patient in the progression of the disease.

Treatment outcome statistics, and attendent costs, must be evaluated as more than mere numbers. While inpatient, outpatient and residential care may enjoy similarly positive success rates, we must remember that these various levels of care are tailored and effective for different populations. Naturally, the more intense the level of care, the higher the price tag. But, appropriateness is the key word here. We would not place a patient experiencing alcoholic psychosis in an outpatient program nor would we necessarily place an individual who is questioning his/her use of alcohol in an acute hospital care unit. The government's responsibility we feel is to ensure the continuation of the diagnostic and placement capability with the professionals to whom the care of its beneficiaries is entrusted.

We believe this comprehensive levels of care system is the model for the 1980's and 1990's that needs to be developed in regional areas.

This concludes my oral statement, Mr. Chairman. I have a longer statement from Lutheran Center for Substance Abuse which I respectfully request be made a part of the permanent hearing record. In addition, the Subcommittee will receive, by mail, a formal written statement from the National Association of Alcoholism Treatment Programs which I also respectfully request be made a part of the same permanent hearing record. I appreciate the opportunity to appear before you today, and would be pleased to answer any questions you might have.

Thank you.

Senator DURENBERGER. Harold?

STATEMENT OF HAROLD SWIFT, ADMINISTRATOR, HAZELDEN FOUNDATION, CENTER CITY, MINN.

Mr. SWIFT. Senator, pleased to be here.

I am the administrator of Hazelden Foundation. For general information, Hazelden Foundation is a nonprofit, charitable organization involved in the field of alcoholism since the late 1940's. We admit approximately 1,600 patients a year coming from all parts of the country and some foreign countries, predominately midwestern, predominately middle class in nature.

The typical patient would spend 20 to 30 days in treatment, and the typical cost for that course of treatment would be $2,800. If a family member chose to participate, it would be an additional $400, for the total cost of a typical course of treatment, $3,200.

It may be of particular interest to you that we are not a medicare provider and have no intentions at this point in time to apply for eligibility as a medicare vendor. Thus I can't give you any detailed comment on the intricacies of medicare funding but will talk in general terms about it.

I would also add that the physical plant of Hazelden has been constructed without benefit of Hill Burton or any other Federal funding.

Our programs were in operation many years before the advent of medicare, medicaid, or any form of third-party reimbursement for the treatment of alcoholism. We found ourselves in a paradoxical situation of having a daily rate that was a fraction of care available in hospitals then the Minnesota legislature changed the insurance laws making freestanding, nonhospital facilities eligible. Of course, that does not include title XVIII or XIX, because Minnesota, as elsewhere in the country, does not provide payment in the freestanding treatment facilities, including Hazelden.

Our publicly funded patients do come to Hazelden from title XX local and general assistance funds. As many as 40 percent of our patients have been publicly funded in the past. Currently, that's down to only about 5 percent of our patient population.

I would suggest that the issue you are dealing with is not so simple as comparing hospitals and nonhospital based programs. I would exercise caution in the generalization that hospitals are more expensive than freestanding or nonhospitals. That is true in most cases, but there are some glaring exceptions to it. We can find nonhospital programs that are more expensive than hospital programs.

I would also express even more caution on the subject of comparing inpatient and outpatient programs. There is a tendency to view these two programs as interchangeable. Both programs can produce good results, outpatient obviously less expensive than inpatient; thus, the false conclusion we should treat all of the alcoholics on an outpatient basis. That tends to overlook the complexity of alcoholism, that the alcoholic population needs a wide variety of treatment services.

I would submit for the record one study conducted by Hazelden entitled "Apples and Oranges," a comparison of inpatient and outpatient programs. That will tell you both programs can produce effective results, but for different kinds of clients, different patients.

[The following was received for the record:]

Apples and Oranges

A Comparison of Inpatient and Outpatient Programs

Jerry Spicer
Leslie R. Nyberg
Thomas R. McKenna

Hazelden

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INTRODUCTION

This is the first major report on the Hazelden Outpatient Program.

Hazelden collects background and outcome data on all clients admitted to its treatment programs and has employed identical instruments and procedures for data collection on both the inpatient and outpatient programs.

Inpatients differ significantly from outpatients on several characteristics. Therefore, simplistic comparisons of outcome may be inappropriate due to the differences in clients.

This report will first examine the literature on the relative effectiveness of inpatient and outpatient programs. Following that section are comparisons of the Hazelden inpatient and outpatient programs, client outcomes, and our conclusions.

REVIEW OF LITERATURE

The literature review focused on studies which, in the past 25 years, compared inpatient and outpatient treatment. In addition to individual investigation, a computer search of the National Bibliographic Retrieval System and the Rutgers Alcohol Information Retrieval System was conducted. Surprisingly, few studies contrasted the effectiveness of the two forms of treatment, and only one of these studies employed random assignment of subjects to treatment. Random assignment is important in comparative research to assure that the programs being compared have similar clients. Here we will summarize some representative studies.

An example of a study which reported both inpatient and outpatient data is the 1963 study by Prothro. This report is typical in concluding that variations in client characteristics and program models make comparisons of inpatient and outpatient programs difficult. Other recent studies (e.g., Matakas et al., 1980) have encountered similar problems. Indeed, one point we will stress is that inpatient and outpatient programs should be evaluated according to their effectiveness with their own clients, and not necessarily as alternative treatments for the same client population.

In England, Edwards and Guthrie (1966, 1967) randomly assigned 40 male, gamma alcoholics to either inpatient or outpatient settings. Average duration of inpatient treatment was 8.9 weeks; average duration of outpatient treatment was 7.7 weeks, with an average of 7.5 clinic visits during that period. (In contrast, the Hazelden outpatient program consists of four three-hour visits per week for four successive weeks.)

A one-year follow-up study found no significant differences between inpatients and outpatients on a measure of consumption, alcohol-related social problems, and alcohol-related medical problems. The authors recommended redeployment of financial resources, with the establishment of a comprehensive treatment service combining inpatient treatment, hostel care, and community liaisons.

Although the Edwards and Guthrie study is probably the best designed comparison of inpatient and outpatient treatment programs, the small sample size (N = 40) and the failure to account adequately for variations in treatment process should be noted. Examination of client characteristics suggests that the attempted randomization was not entirely successful. For example, although marital status has frequently been found to be predictive of treatment outcome, 16 outpatients and only 12 of the inpatients in the Edwards and Guthrie study were married and living with their wives; six of the inpatients and only two of the outpatients were separated and divorced. Because the authors do not discuss treatment dropouts, a significant problem in outpatient treatment of alcoholism, the reader must assume that all subjects completed treatment and responded to follow-up.

Smart et al. (1977), examined 183 subjects who, following admission to a detoxification center, *chose* to participate in halfway house, hospital, or non-residential treatment; thus, subjects were not randomly assigned. Subjects showing fewer detoxification admissions during the year following treatment than in the year prior to treatment were considered "improved," and improvement rates for the three treatment locations were compared. The improvement rate for non-residential treatment (23.8%) was slightly higher than rates for hospital (18.2%) or halfway house (16.7%) treatment.

Smart et al. reported relatively few measures of client

characteristics, but their subjects seem to represent a large proportion of skid row alcoholics. Length of treatment, amount of treatment, type of treatment, and therapist characteristics for the three locations were not reported, although it was admitted that some hospitals were actually psychiatric hospitals offering no specific alcoholism treatment. Difficulties in research design severely limit the conclusions that can be drawn from this study. The very low improvement rate for these subjects (19.7%), despite generous criteria for "improvement," underscores the difficulty of treating alcoholics with extremely poor pre-treatment adjustment. Subjects referred to hospital treatment were more likely to appear for treatment (51%) than were subjects referred to non-residential treatment (22%). Subjects treated in hospitals were more likely to complete treatment (95%) than were subjects undergoing non-residential treatment (33%). The higher rate of treatment completion among inpatients is compatible with previously reported higher dropout rates in outpatient programs.

Perhaps the best known, and most controversial, comparison of inpatient and outpatient programs is the continuing study sponsored by the Rand Corporation. Results of the study were first published as a Rand Corporation report (Armor et al., 1976) and later published in an expanded version (Armor et al., 1978). Recently, results of a four-year follow-up have been published (Polich et al., 1980). The Rand study employed the NIAAA monitoring system, which contains client, treatment, and outcome data on 44 alcoholism treatment centers (ATCs) throughout the country (Armor et al., 1978). A special 18-month follow-up study was conducted using 1,340 clients sampled from the ATCs. It should be noted that the follow-up study did not employ random assignment of subjects and that the response rate was 62%.

Results of the 18-month follow-up indicated a mean total remission rate of 69.1% for the eight ATCs, with a range of 49% to 81%. The authors observed that the results were similar, arguing that one treatment center had a low remission rate (49%), but that other centers varied only from 63% to 81%. Although sufficient data are not supplied to conduct a statistical comparison of ATC remission rates, it is arguable that there is considerable clinical difference between an 81% remission rate and a 49%, or even 63%, rate.

The variability among ATCs suggests that one important research question pertains to characteristics which differentiate between most and least successful treatment centers. Examining characteristics of ATCs, the Rand study found no significant relationship between 18-month remission rates and breadth of treatment program. Armor et al. did find, however, that patients receiving a high amount of treatment had significantly higher remission rates than did patients receiving low amount of treatment. This finding held true whether patients received the high amount of treatment for a short duration of time (i.e., intensive treatment) or over a long period (i.e., extensive treatment).

Recently, Stinson et al. (1979) found that differences in client outcome may be due to amount of client-counselor and peer interaction, rather than inpatient-outpatient program models. This finding is somewhat corroborated by another facet of the Rand study, in which it was found that participation in Alcoholics Anonymous groups raised remission rates from 55% to 71% for clients receiving little or no ATC treatment. For clients who had, however, received substantial ATC treatment, participation in Alcoholics Anonymous raised remission rates only slightly, from 83% to 84%. Another significant factor appeared to be client symptoms at intake: clients exhibiting less severe problems achieved higher remission rates across all settings.

The Rand study, then, found no significant difference in

remission rates between inpatient and outpatient settings, when differences in client characteristics were statistically eliminated. Amount of treatment, however, whether occurring over a short period of time (intensive treatment) or for a longer duration (extensive treatment), was significantly related to outcome.

In summary, current research comparing inpatient and outpatient programs is not conclusive in its findings. Studies have not controlled for client characteristics, used random or matched samples, or used standard definitions of "inpatient" and "outpatient." The central issue may be which program models are most effective with specific client populations (Matakas, et al., 1980; Miller and Taylor, 1980; Sanchez-Graig, 1980).

PROGRAM DESCRIPTIONS

Hazelden Non-residential Rehabilitation Program

The Hazelden non-residential or outpatient rehabilitation programs are alternatives to residential programs for people who can function in the community while learning a new life-style. Hazelden provides outpatient services at three clinics. Two are located in the Twin Cities area and the third, serving a rural population, is located in Cambridge, Minnesota.

Hazelden outpatient programs are based on the principle that many chemically dependent people have the capacity to abstain from mood-altering chemicals, to demonstrate responsibility, to realize personal growth and change, and to maintain meaningful and workable relationships with other people. The goals of the outpatient programs are to encourage chemically dependent people to achieve abstinence from mood-altering chemicals and to improve the overall quality of their lives.

Four basic services are provided by the outpatient programs: assessment, chemical dependency treatment, the family program, and aftercare support. The assessment process is completed by outpatient program counselors and is followed by admission to treatment or referral to other agencies and services. Tentative admission is given upon completion of three assessment components: (a) a diagnosis of the client's chemical dependency using the Jellinek signs and symptoms (Jellinek, 1952); (b) a complete medical, social, psychological, legal, and employment history; and (c) evaluation of the client's ability to

fulfill the financial obligations of the program. A multiple-funding approach is used to facilitate the client's entry to treatment, including free service and third-party payment.

The client, if diagnosed as chemically dependent and physically capable of participating, is admitted to the outpatient program. This is a tentative admission; continued involvement depends upon the client's ability to remain abstinent and to maintain daily attendance. During a one-week observation period, clients are given a Minnesota Multiphasic Personality Inventory and a Shipley-Hartford Intelligence Screening Test. Test results are reviewed by the program psychologist and are used in determining if the client is appropriate for outpatient treatment.

Patients who are refused admission to outpatient programs include those who do not remain sober or attend all sessions, those who are not physically able to attend each evening, those who may need medical attention for withdrawal symptoms, and those who are emotionally disturbed and need more structured supervision and attention. Such clients are typically referred to inpatient programs. Approximately 35% of persons contacting the outpatient program are referred elsewhere.

Three major types of clients are served by the outpatient program. First, clients diagnosed as chemically dependent who are not appropriate for residential care. Second, other clients diagnosed as dependent who refuse to accept referral to inpatient treatment, but are able to function within the structure of the outpatient program. Third, clients recently discharged from inpatient treatment who need a highly structured aftercare program.

The outpatient program includes all the basic elements of a residential program: (1) psychological testing and evaluation, (2) interviews with chemical dependency counselors, (3) interviews with clergy and family counselors, (4) family conferences, (5) lecture groups based upon the Steps of

Alcoholics Anonymous, and (6) support groups. Group sessions are conducted for four weeks, Monday through Friday, with each evening session lasting three hours. Individual counseling sessions and conferences are scheduled in addition to lectures and groups. Each client spends a minimum of 60 hours in groups and lectures during the four-week session, a minimum of two hours per week in individual counseling, and approximately 15 hours in aftercare groups.

The outpatient program also provides a four-week Family Program for family members of those who are alcoholic and chemically dependent. The Family Program provides support groups, lectures, and counseling services received by clients in the chemical dependency program, as well as an introduction to the Al-Anon Steps and program. (However, no psychological testing is conducted.) The program is intended to serve as a form of education as well as intervention for family members. Family Program clients receive a minimum of 16 hours of group therapy and lectures each week, three one-to-one counseling sessions during the four-week program and one and one-half hours of aftercare each week. All clients in the chemical dependency program are expected to have a "significant other" person in the Family Program. The Family Program is also open to the community, and family members may attend without a member being involved in the chemical dependency program.

Aftercare sessions are conducted for recovering chemically dependent people following treatment in any Hazelden rehabilitation program. The Aftercare Program consists of ten lecture-group sessions. These two-hour sessions are held once a week, are designed to provide support to people making the transition from rehabilitation programs, and are focused on the aftercare plan of the client. Aftercare is also provided for family members.

Hazelden Residential Rehabilitation Program

The Hazelden Primary Rehabilitation Program provides inpatient (residential) services to over 1,500 chemically dependent men and women annually. Facilities include 128 beds in single and semi-private rooms in six primary rehabilitation units, a 22-bed medical services and detoxification unit, an 18-bed family program unit and a 23-bed extended care unit. The primary rehabilitation period lasts an average of four weeks, although length of stay depends on the nature and severity of the individual patient's condition.

Hazelden views chemical dependency as a complex, multifaceted illness, and for this reason physical, mental, social, and spiritual factors are included in the rehabilitation program. Hazelden therapy and aftercare emphasize the self-disciplinary measures practiced by Alcoholics Anonymous, with a goal of total abstinence.

The primary rehabilitation program uses individual counseling as well as peer and group therapy. Counselors work with each person to identify problems and to develop an individual rehabilitation plan. The rehabilitation staff includes psychologists, registered nurses, psychiatrists and other medical doctors, individual and family counselors, and clergymen of various denominations. Group therapy and peer interaction combine to produce a therapeutic environment in which patients help themselves by helping each other.

Hazelden's lecture series is an integral part of the primary rehabilitation program. Patients attend an average of 80 lectures during their stay at Hazelden.

Alcoholics Anonymous is recognized by Hazelden as the most valuable and available means of achieving continuing sobriety. Orientation to the philosophy and practice of the Alcoholics Anonymous Steps and Traditions is an important part of primary rehabilitation and referral to A.A. plays a major role in the development of each patient's aftercare plan.

COMPARISON OF HAZELDEN INPATIENT AND OUTPATIENT PROGRAMS

Methodology

Data for this study were collected by several departments. Client background variables were documented in the clients' files by outpatient staff. Medical Records entered some of these variables onto Abstracting Forms which were then computer-entered. Additional information on all outpatients and on a random sample of 116 inpatients was collected in order to determine differences in client background and psychological well-being. The Quality Assurance Department assisted in designing instruments to collect these data. Psychological variables were measured by the Minnesota Multiphasic Personality Inventory (MMPI), which is administered to Hazelden clients within the first week of treatment.

The Evaluation and Research Department was responsible for the follow-up evaluation process. After receiving a release form, questionnaires were sent to the clients at six and twelve months after discharge. Persons not responding to the mailed questionnaire were interviewed by telephone. Questionnaires were also sent to a confirmant in order to validate the data.

Client Characteristics

Inpatients and outpatients varied on demographic and socioeconomic characteristics. While approximately three-fourths of both populations were male, inpatients were older than outpatients and less likely to be married. Socioeconomic status of inpatients was somewhat higher. Perhaps the most pronounced difference between the two populations was geographical, with almost all outpatients (99%) and only one-third of inpatients being Minnesota residents.

Equal numbers of inpatients and outpatients reported alcohol-related arrests prior to admission (68% vs. 67%). *Inpatients, however, were significantly more likely to report previous hospitalizations.* Inpatients with previous hospitalizations have been found (Laundergan, 1980) to have a more difficult time maintaining sobriety than those with no prior treatment.

Using a modification of the Jellinek symptomatology (Jellinek, 1952), all patients were examined for the presence of 31 signs and symptoms of alcoholism. These signs and symptoms included, according to the Polich et al. (1980) findings, the following indicators of physiological dependence: tremors, morning drinking, loss of control, blackouts, and continuous use for a period exceeding 18 hours. The proportion of inpatients and outpatients endorsing each of the signs and symptoms is presented in Table 1.

As Table 1 indicates, *inpatients were more likely than outpatients to endorse 30 of the 31 symptoms, and the difference was statistically significant for 20 of the 31 symptoms.* Jellinek (1952) arranged the symptoms in an order that represents increasing severity of alcoholism. For that reason, it is interesting to note that inpatients were significantly more likely than outpatients to endorse 15 of the last 16 signs and symptoms, but that endorsement rates did not differ significantly on 10 of the first 15 symptoms. The data suggest that inpatients endorsed both a larger number and more serious kinds of symptoms than did outpatients, leading to the inference that inpatients suffered from more severe alcoholism

Table 1

Symptomatic Use of Chemicals

DIAGNOSTIC SYMPTOMS:	PERCENT ENDORSED		STATISTICAL TESTS:		
	In-patient	Out-patient	X^2	SIG	PHI
1. Increased tolerance	100%	99%	-	n.s.	-
2. Loss of memory-temporary	84	85	-	n.s.	-
3. Sneaking chemicals	89	63	19.8	.0001	.30
4. Preoccupation	93	87	-	n.s.	-
5. Hurried ingestion	91	77	8.8	.0003	.20
6. Avoid reference to use	84	68	8.3	.004	.10
7. Loss of memory-frequent	73	66	-	n.s.	-
8. Loss of control	96	94	-	n.s.	-
9. Alibis	90	85	-	n.s.	-
10. Reproof by significant other	95	82	8.8	.003	.20
11. Extravagance	93	91		n.s.	-
12. Aggression	83	73	-	n.s.	-
13. Persistent remorse	89	87	-	n.s.	-
14. Periodic abstinence	93	87	-	n.s.	-
15. Change in usage pattern	90	73	11.2	.001	.22
16. Loss of friendship	71	55	6.0	.02	.16
17. Loss of position	66	29	31.6	.0001	.42
18. S.O. change habits	89	78	5.0	.03	.15
19. First treatment	96	61	39.2	.0001	.42
20. Resentments	89	78	5.0	.03	.15
21. Escape	89	55	33.2	.0001	.39
22. Protecting supply	87	75	5.2	.04	.15
23. Morning usage	91	78	7.1	.01	.18
24. Continuous use	79	64	6.0	.02	.16
25. Ethical deterioration	89	72	9.6	.002	.21
26. Inappropriate thinking	91	64	23.1	.0001	.33
27. Decreased tolerance	76	51	15.9	.0001	.27
28. Indefinable fears	71	62	-	n.s.	-
29. Tremors	69	43	15.1	.001	.26
30. Psycho-motor inhibitions	75	40	26.2	.001	.35
31. Spiritual need	90	60	28.3	.001	.36

*E.M. Jellinek. "Phases of Alcohol Addiction," *Quarterly Journal of Studies on Alcohol*, 1952, 13,763-684.

than did outpatients.

Inpatients were more likely than outpatients to experience changes in their lives as a result of drinking: inpatients were more likely to have undergone some kind of treatment, to have lost a job or position, or to have tried to escape the effects of

their drinking. Somewhat less pronounced is the indication that inpatients were more likely to have experienced decreased tolerance, morning usage, tremors, and continuous usage for a period exceeding 18 hours.

Diagnostically, patients admitted to treatment are classified as Prodromal, Crucial, or Chronic alcoholics on the basis of the Jellinek (1952) symptomatology. *Of the inpatients, 98.3% were diagnosed as Chronic Alcoholics, compared to 85.7% of the outpatients.*

Measures of quantity were converted to standard, one-ounce units of absolute ethanol. *Mean daily intake for inpatients was 21.2 ounces, compared to a mean of 14.6 ounces for outpatients.* Much of this difference may be accounted for by the fact that 40% of the outpatients reported drinking between one and 10 ounces of ethanol per day, compared to only 17% of inpatients.

Measures were also taken of the pattern and duration of alcohol use. There was no relationship between pattern of use (continuous, episodic, etc.) and treatment location. While duration of alcohol *use* was longer for inpatients, there was no significant difference in the duration of alcohol *abuse* (defined as time between first intoxication and admission to present treatment).

Psychological Well-being

Of 121 outpatients, 104 had completed an MMPI. This group was compared to a random sample of 121 Hazelden inpatients, 116 of whom completed the MMPI. Two-tailed, independent sample t-tests contrasted inpatients and outpatients on MMPI validity, clinical, and special scales. A comparison of MMPI scores is presented in Table 2; a visual profile of the validity and clinical scales is presented in Figure 1.

Table 2

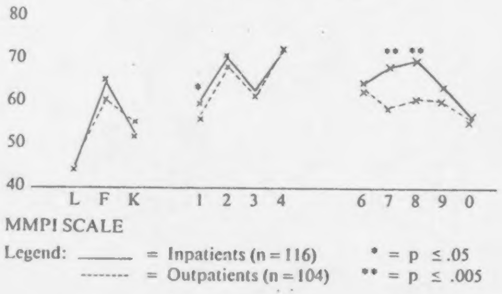
Inpatient vs. Outpatient MMPI Scores

(Two-tailed, independent sample t-tests)

MMPI Scale	Treatment Location		Significance
	Inpatient (N = 116)	Outpatient (N = 104)	
L } Validity scales	46.8	46.3	n.s.
F } Validity scales	64.2	62.7	n.s.
K } Validity scales	51.0	53.1	n.s.
1— Hypochondriasis	60.3	56.5	p<.05
2— Depression	71.0	66.0	p<.03
3— Hysteria	63.6	62.7	n.s.
4— Psychopathic Deviate	71.9	71.8	n.s.
6— Paranoia	64.0	62.8	n.s.
7— Psychasthenia	67.9	59.8	p <.001
8— Schizophrenia	68.6	61.7	p <.003
9— Mania	63.1	60.6	n.s.
0— Social Introversion/Extroversion	55.3	56.0	n.s.
Pd 1— Familial Discord			
Pd 2— Authority Problems	58.4	62.0	p<.05
Pd 3— Social Imperturbability	58.8	61.5	n.s.
Pd 4A— Social Alienation	48.7	46.3	n.s.
Pd 4B— Self Alienation	60.2	57.3	p<.05
MacAndrew Alcoholism	66.0	63.3	n.s.
Scale	26.7	25.0	p <.008

Figure 1

Inpatient vs. Outpatient MMPI Scores



As Figure 1 indicates, *inpatient clinical scales show a generally greater elevation than do outpatient MMPI profiles, suggesting a generally higher level of psychopathology among inpatients.* Significant differences were found on Scales 1, 2, and especially, Scales 7 and 8. Individual scale differences suggest that, in addition to generally greater psychopathology, *inpatients reported more somatic complaints* (Scale 1), *more severe depression* (Scale 2), *more anxiety* (Scale 7), *and more bizarre thoughts and behavior* (Scale 8). Inpatients, then, apparently experience increased levels of subjective distress, depression, and anxiety (Scales 2 and 7), and are more likely to exhibit schizoid and pre-psychotic tendencies (Scales 2, 7 and 8). Interestingly, scores on Scales 4 and 9 were virtually identical, suggesting that the proportion of alcoholics with sociopathic tendencies may be approximately equal in these inpatient and outpatient populations.

Although analyses of two-point and three-point code types were not conducted, elevations on Scales 2, 7 and 8 suggest that inpatients may be more likely to experience difficulty in establishing warm, rewarding relationships. They are more likely to be introverted and socially withdrawn, lacking social skills, and perceived by others as being cold and aloof. Inpatient elevations on the depression scale (Scale 2) and on Scales 7 and 8, also associated with depression (Hathaway and Meehl, 1978), point to a substantially greater frequency of depressive disorders among inpatients.

MMPI special scales are presented in Table 2. The Harris-Lingoes subscales indicate that outpatients are more likely to report familial discord than are inpatients, but that inpatients are more likely to report social alienation. The latter finding is compatible with the social withdrawal suggested above. *Inpatients scored higher than outpatients on the MacAndrew Alcoholism Scale, suggesting the possibility of more severe alcoholism among the inpatients.*

Client Outcomes

Table 3 summarizes outcomes of treatment for inpatients and outpatients admitted to treatment in 1978. Caution should be taken in interpreting these data. The number of clients (80) in the outpatient sample is too small to permit generalizing to all outpatient programs or to allow us to assume that inpatient and outpatient similarities will continue over time. However, as we noted, the literature typically finds the outcomes of inpatient and outpatient programs to be similar and the reader should use Table 3 as illustrative of these studies.

Inpatients and outpatients report almost identical outcomes one year after treatment, with inpatients reporting a slightly lower rate of alcohol and other drug use and a higher rate of involvement in Alcoholics Anonymous. Previous research at Hazelden has demonstrated relationships among completing treatment, attending Alcoholics Anonymous, and maintaining a drug-free life. This may be associated with the somewhat lower recovery rate for the outpatients, as fewer outpatients (74%) completed treatment compared to the inpatients (85%). Outpatients also participated less frequently in Alcoholics Anonymous after treatment (Table 3). Completing treatment and using A.A. as a follow-up support system may enable clients to receive more extensive amounts of treatment, which Armor et al. (1978) found to be important in explaining recovery.

Table 3

Inpatient and Outpatient Outcomes,
On Selected Variables, One Year
After Treatment (%)

Variable	Inpatient	Outpatient
Chemical Use		
No use of alcohol since treatment	64%	62%
No inappropriate use of other mood-altering drugs since treatment	90%	84%
Participation in Alcoholics Anonymous		
Currently attending A.A.	74%	61%
Did 12th Step Work	60%	50%
Maturation and Growth, "Improvement in . . .		
Relationship with Higher Power"	82%	76%
Relationship with Spouse"	79%	78%
Self Image"	87%	88%
Ability to handle problems"	87%	85%
General enjoyment of life"	84%	82%
General physical health"	74%	70%
Ability to manage financial affairs"	71%	60%
Participation in community affairs"	45%	42%
N*	959	80

*Note: The inpatient and outpatient data are based on all available returns for 1978 clients. Of the 1,558 admissions to the inpatient program, 280 persons were not sent questionnaires (refusals, deceased, short-term clients, etc.). Seventy-five percent of the remaining 1,278 inpatients returned a questionnaire or were interviewed by telephone. Of the 121 admissions to the outpatient program, 28 persons were not sent questionnaires. Eighty-six percent of the remaining sample responded.

CONCLUSIONS

In summary, a direct comparison of these inpatient and outpatient treatment programs may be inappropriate. *Psychologically, inpatients exhibited generally greater psychopathology*: they reported more somatic complaints, more depression, more anxiety, and more bizarre thoughts and behavior. Inpatient elevations on MMPI Scales 1, 2 and 7 suggest that inpatients were more likely than outpatients to exhibit neurotic tendencies; furthermore, inpatient elevations on Scale 8, as well as the 2-7-8 elevation, suggest more schizoid and pre-psychotic tendencies among inpatients. Social alienation and withdrawal seem to characterize a greater proportion of inpatients.

Inpatients scored higher than outpatients on the MacAndrew Alcoholism Scale, were more likely to be diagnosed as Chronic Alcoholics, and endorsed more of the Jellinek alcoholism symptoms. Inpatients were more likely to endorse such symptoms of physiological dependence as tremors, morning drinking, and continuous use beyond an 18-hour period, and inpatients were more likely (47% vs. 7%) to report previous hospitalizations. Inpatients consumed more alcohol than did outpatients. Although inpatients had a longer duration of alcohol use, there were no significant differences in pattern of use or duration of alcohol abuse.

This comparison of inpatient and outpatient client characteristics found that inpatients have more severe alcohol-related problems and symptoms. The major implication of this study is to call into question earlier statements regarding the relative effectiveness of inpatient and outpatient programs (e.g. Armor et al., 1978). Although outcomes are similar, client characteristics and program processes are different. Client variables may influence outcomes, and comparisons of inpatient and outpatient programs should either control for such variables or employ random assignment of subjects.

Because of differences in client characteristics, the most accurate conclusion may be that the inpatient and outpatient programs are equally effective with their appropriate clients. However, we cannot assume that all clients would benefit from either program. Both programs have adapted their processes to their client populations and may not be as effective with a different type of client. It is also inappropriate to group short-term hospitalizations with 32-day residential programs or five-session outpatient programs with 20-session programs. Programs using treatment models that differ in philosophy and intensity should avoid direct comparison of outcomes.

Future research should attend to characteristics of the most successful inpatient and outpatient treatment centers, as well as contrasting successful outpatient centers with successful inpatient centers. The most important treatment characteristic in achieving successful outcomes has yet to be conclusively demonstrated, although amount of treatment is currently the most likely candidate.

Given the limited generalizations of inpatient and outpatient studies, concluding that all inpatient or all outpatient programs should be eliminated is unwarranted. Local comparisons of available inpatient and outpatient programs would, however, seem to be an important part of a cost-effectiveness study. But it is important that such comparisons attend to (a) possible heterogeneity within local inpatient and outpatient settings, (b) heterogeneity of client characteristics between inpatient and outpatient settings, and (c) level of program intensity and peer support. For local communities, the evaluation question may not be "Which is more effective, inpatient or outpatient treatment?" but rather, "Which of our facilities is most appropriate for treating this type of client with these problems?"

Mr. SWIFT. So I am suggesting it is not safe that a given patient could be put in an outpatient program and one would assume a good outcome. This might be particularly true of the elderly patient. An outpatient alcoholism program is a rigorous, physically demanding program—to get to the clinic 3, 4, 5 nights a week, get back to work, live with your family, and in the meantime don't drink or use any kind of mood-altering chemicals. It is a very demanding regime.

Aside from the location of a program, hospital or nonhospital, the more important issue is quality. We suggest you will find a wide variety of costs throughout the field and a wide variety of quality. You will find a wide variety of quality across profit and nonprofit. Neither one has a monopoly on quality. There are some good examples of good proprietary programs, and there are some examples of poor, nonprofit programs, in terms of quality.

It is clear that the present medicare funding is restricted to one category of facility that is typically described as a "hospital" and accredited by the joint commission as such.

I would suggest, as a measure of quality, that the joint commission accredits alcoholism programs under a set of standards called the Consolidated Standards. I would suggest you consider them as one measure of quality—not to say they should be mandated for alcoholism programs, but it is just one measure.

Many States have produced licensing laws for alcoholism programs that run parallel to the Joint Commission. An example would be Wisconsin. Those particular State licensing laws can be seen as a measure of quality for alcoholism programs.

Back to the issue of cost, there are many variables in cost: Local labor costs, malpractice insurance, institution overhead. The most significant variable is the intensity of care. That variable can tend to increase the costs of a program. One can contrive an alcoholism program using, say daily, one-to-one sessions with a highly paid professional staff member, or you could conduct group therapy with a qualified counselor on alcoholism. Both could produce respectable results. One would be a good deal more expensive than the other. Both would be reimbursable.

On the type of modality or philosophy, I am sure you are aware there are many different approaches to the treatment of alcoholism. They can all claim good results. The aversion programs can claim good results, so can the multidisciplinary AA-oriented types of programs. You can't pin the animal down by looking at the philosophical base of the treatment program.

In the case of medicare coverage, again I suggest it is restricted to one type of facility, and it tends to be more costly. It doesn't tend to respect the needs of the patient. In the process, the medicare system is passing up bargains in the form of certain nonhospital programs in certain areas of the country.

There is a concern, if we expand benefits won't we increase costs? I would say that out of the pool of nonhospital based programs that might be considered as eligible for medicare potential—future medicare vendors—that all will not apply for that status, that some will choose not to meet the current medicare standards, including Hazelden, that it would modify our physical environment and tend to increase our costs, that we would wind up looking more like a nursing home than what we look like now.

In short, the expanding coverage of medicare may not produce as many new vendors as some people would predict.

I suggest changes in the medicare system, focusing on a cost benefit for a course of treatment rather than on the locus of the treatment, but it is to look at the cost of a type of program rather than the location.

Another approach might be a cap on a course of treatment for alcoholism. We hear a lot about programs in the $6,000 to $12,000 range, and they get a lot of press. On the other hand, there are many programs around on the $3,000 to $4,500 range that are reputable effective programs, both nonhospital and hospital programs.

The present third party system, medicare included, is devoid of price competition. The present system is focused and shaped by regulatory agencies and the third-party payment system. The former, the regulatory system, inherently increases costs; the latter tends to increase the intensity of care and subsequently the cost of care. Neither provide for cost effectiveness, neither provide incentive to contain cost and have no incentive for the low-cost provider.

Also, at present the consumer has no incentive to seek lowercost care. They may even believe that expensive is better. We can find in some communities cost of hospital care for a specific surgical procedure can vary as much as 400 percent from hospital to hospital in the same general community.

A copay system is the traditional approach to asking the consumer to participate in and be aware of the cost. Perhaps a copay system with a sliding scale that greatly increases the incentive to the consumer to opt for lower cost care. To have a consumer pay 25 percent of a $10,000 program is a big expense to the consumer. To have the consumer perhaps pay 10 percent or 5 percent of a $3,200 program might be an incentive to the consumer to seek out lower cost care.

There are good studies on cost benefit of treatment of alcoholism. A study conducted by a consortium of hospitals in the Twin Cities area is strongly indicative of the financial benefits of treatments even in hospitals.

The cost of nontreatment must be addressed. The drinking alcoholic creates untold cost to the health care system, including medicare. Further, in my own experience, some older people will not go to a hospital. They won't even go to a hospital to visit their friends when they are sick—they are just afraid of hospitals. Providing options other than hospital might encourage older citizens to seek treatment, and thus ideally create a long-term reduction in health care costs to medicare.

In summary, and to repeat some of the things I have said, debate should ideally not be confined simply to hospital versus nonhospital, inpatient versus outpatient. The cost of a good outpatient program in the District of Columbia might be $3,000. You could get the same cost from 30-day residential care in the Midwest.

We need to consider the type of patient to be served, the type of services offered, the level of intensity, and the related question of cost and efficacy of the intense programs.

Quality is one measure. Consider JCAH Consolidated Standards and some of the good State licensing laws.

Creation of incentives for cost containment—not by traditional means of rate review and regulation; creation of incentives for cost competition; incentives for low-cost vendors; perhaps, again, a cost cap for a course of alcoholism rehabilitation; perhaps a cap plus copay system with a sliding scale to give the consumer a lower cost program.

[The prepared statement of Harold Swift follows:]

Hazelden

July 23, 1982

Mr. Robert E. Ligthizer
Chief Council
Finance Committee
2227 Dirkson Office Building
Washington, D.C. 20510

Dear Mr. Ligthizer:

It has been requested by Mr. Stanco to submit material in advance of testimony to occur on Tuesday, July 27 on the subject of alcoholism and Medicare reimbursement.

I've enclosed one copy of my resume in order to provide you with some of my background in the field of alcoholism.

My position is Administrator of Hazelden Foundation. I have been employed by Hazelden Foundation for 16 years. I have been involved in the field of alcoholism for approximately 22 years.

Also, in the way of introduction, I will attempt to describe Hazelden Foundation. Hazelden Foundation is a non-profit, charitable organization providing a variety of services in the field of alcoholism. Hazelden attempts to offer a full continuum of care to the alcoholic in the form of rehabilitation services, training of alcoholism counselors and clergy persons, research and evaluation and a variety of publications, in printed and audio/visuals forms.

The rehabilitation services provided by Hazelden include detoxification, evaluation, residential primary rehabilitation, also known as residential care, extended residential rehabilitation, halfway house facility, aftercare, family programs, employee assistance programs, and outpatient services in three locations in Minnesota. This includes total bed capacity at three locations in Minnesota of 310 beds for treatment of adults, adolescents and halfway house services for both men and women. Hazelden's alcoholism rehabilitation programs have been in operation since the late 1940's.

The philosophical approach of Hazelden to the rehabilitation/treatment of the alcoholic is highly oriented toward the concepts of Alcoholics Anonymous, our desired outcome of treatment is total abstinence from alcohol and other mood-altering substances, as well

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as improvement in quality of life for the patient. This includes a strong emphasis on the multidisciplinary staff, which includes counselors, clergymen, physicians, nurses, psychologists, family counselors, psychiatrists and related professionals.

Hazelden Foundation has primary facilities located in Center City, Minnesota, with other facilities located in St. Paul, Minnesota, and Plymouth, Minnesota. Patients entering Hazelden's programs come from all parts of the U. S. and some foreign countries. The predominant socio-economic patients would be described as coming from the mid-western states. Their socio-economic background is typically middle class, also including patients from the high and low end of the socio-economic scales.

A typical patient in our primary rehabilitation (residential) program spends 28 to 30 days in treatment. At the present time, the charge for such a course of rehabilitation would total approximately $2800. If a family member chose to participate in the five-day residential family program, it would be an additional charge of $400. Total charge for the patient and the family member would be approximately $3200. The charge for outpatient treatment is a total of $750 for three nights a week, for four weeks, including the family members and aftercare services. The rehabilitation programs are financed by private fees, third-party payment and donations.

Perhaps of particular interest to you is that Hazelden is not a Medicare provider. Nor at this time do we have any plans to apply for eligibility as a Medicare provider. Thus, I would say that I cannot comment in any detail or a reliable manner on the intricacies of Medicare financing of alcoholism treatment programs. I will comment on that subject only in broad and general terms. Publicly funded patients receiving treatment in various Hazelden programs are funded by county welfare departments, utilizing Title XX and/or local general assistance funds. If public, private or third-party payment is not available, Hazelden provides some free care.

I would also add, for the background, that the Hazelden physical plant has been constructed without benefit of Hill Burton or other public funds. Of our total patient population, funded via public fund, has been as high as 40% of our total revenue. This has decreased over the recent years to less than 5% of total revenue at present.

Hazelden Foundation alcoholism rehabilitation programs were in operation many years before Medicare and other forms of third-party payment were available for treatment of alcoholism. With the advent of commercial, Blue Cross, Title XVIII, XIX coverage, we found ourselves in a paradoxical situation. In the late 1960's, a Minnesota citizen with any form of third-party coverage, including Medicare or Medicaid was limited in their choice of treatment facilities to those programs located in hospitals. Non-hospital based programs, such as Hazelden, were categorically excluded from third-party reimbursement. The paradox that may be of interest to you is the fact that the fee for non-hospital based care was considerably less than hospital-based care. This eventually led to modifications in our state insurance laws to mandate third-party reimbursement in licensed non-hospital treatment programs (excluding the federally funded Title XVIII and XIX programs). That situation continues to this day with the federal programs, which still mandate the Medicare and Medicaid patient to seek treatment in a hospital-based program, rather than non-hospital. In the case of alcoholism treatment programs located in Minnesota, the publicly funded patient is, thus, required to seek treatment in what tends to be the more expensive programs.

Further, on the subject of hospital/non-hospital based alcoholism treatment programs and inpatient vs. outpatient treatment, I would suggest there are very few simple choices. While with reference to Minnesota treatment programs, I could generalize to an extent to say that non-hospital programs are less expensive than hospital programs. I would urge caution in extending that generalization. I am sure there are non-hospital based programs in certain parts of the country that are more expensive than hospital-based programs. Thus, in examining cost we cannot and should not generalize by type of facility.

While examining the merits of inpatient vs. outpatient program, I would exercise even greater caution. There is a tendency to view the two type of programs or facilities as interchangeable in the treatment of alcoholism. Both types of programs can produce satisfactory results.* The outpatient program is obviously less expensive than inpatient. Thus, we can reach the false conclusion that alcoholics should be treated on an outpatient basis. That type of logic tends to overlook the fact that alcoholism is a complex condition--that the alcoholic patient population needs a wide variety of treatment services. There are, indeed, certain individuals who are sufficiently stable to profit from outpatient programs. There are, obviously, a large number of alcoholics who need the structured environment afforded in inpatient or residential programs. Those individuals who do not have sufficient emotional and physical strength to participate in an outpatient program, while at the same time, living with the family and remaining on the job in their own community.

*Apples and Oranges--A comparison of inpatient and outpatient programs; Hazelden Foundation, 1981.

Thus, I would recommend that in considering the cost of alcoholism, that you give careful consideration to the various levels of care necessary for the alcoholic population at large. Various levels of treatment programs include short-term detoxification, inpatient or hospital care, residential or non-hospital care, day care, extended or long-term care, halfway house services, and outpatient care. The per day cost of those services, of course, decreases with the high cost of detox and inpatient care, down to the lower cost of outpatient care.

The quality of a program cannot be judged solely by its corporate structure. You will find as wide a variety of quality as you do of cost. You will find the same issue if you compare profit and non-profit programs. There are profit programs with high quality and, of course, there are some non-profit programs with low quality. And the converse is also to be looked at.

The one thing that is clear is that Medicare funding is restricted to one general category of facility, which is typically described as a hospital and accredited by the Joint Commission on Accreditation of Hospitals.

On addressing the issue of how to measure quality in alcoholism treatment programs, I would suggest you examine carefully the Joint Commission on Accreditation of Hospital standards. The Joint Commission accredits alcoholism programs under a set of standards called the Consolidated Standards. These are aimed at psychiatric programs, as well as alcohol and drug programs. It is my personal opinion that the Consolidated Standards published by Joint Commission are of a good measure of quality. The only national set of standards, which I'm aware of, is any degree of credibility in the health care community. I'm not suggesting that JCAH accreditation under the Consolidated Standards be mandated for alcoholism programs, as a condition of reimbursement, but it is certainly one of the best measures of quality available to you. Many states have adopted licensing laws for alcoholism programs that are quite similar to the JCAH accreditation, e.g., Wisconsin. Those state licensing laws for alcoholism programs could also be seen as a measure of quality.

Back to the issue of cost, there are many variables involved. It is not a simple issue of hospital vs. non-hospital and, as mentioned above, outpatient vs. inpatient. Local labor costs, institutional overhead have significant impact on cost. Other issues, such as malpractice insurance, can vary. I would venture a guess that the most significant variable in cost is the level and type of services provided. One could contrive an alcoholism program providing expensive services. The question would be how relevant are those services to achieving abstinence from alcohol and other mood-altering drugs. For instance, one could envision daily hour-long one-to-one interviews with a highly paid professional staff member, compared to group therapy conducted by a qualified counselor on alcoholism. The former would be a more expensive addition to the daily treatment regime and probably not necessary for all of the patients in the program. It might, however, be necessary on an individualized basis in that program.

I am sure you are or will become aware of the fact that there are a number of different approaches to the treatment of alcoholism, ranging from the concepts of Alcoholics Anonymous to aversion therapies. I will not argue that one is more effective than the other. Both types of programs can demonstrate positive results. Once again, costs will vary.

As I understand it, you are addressing the issue of Medicare coverage, with the possibility of expanded Medicare coverage for treatment of alcoholism. I'm sure the question has risen if we expand coverage, will we expand cost.

I have read comments from individuals suggesting that expanding coverage to other than hospitals would ultimately increase the cost. I won't pretend to be able to forecast the long-term outcome of changes in the Medicare law. I would, however, suggest that it is clear that in certain areas of the country, present Medicare law forces patients to seek the more expensive option. And a change should result in some cost savings. However, the history of the treatment of alcoholism would indicate there are individuals suffering from alcoholism who, for one reason or another, have not yet participated in alcoholism rehabilitation programs. As we become more aware of the alcohol problem in the country, there should be more patients in treatment for alcoholism funded by Medicare and other third-party payment mechanisms. In other words, I think this country has only begun to scratch the surface in treatment of alcohol and drug problems. If we address that issue in a conscientious manner, we will, indeed, in the future see more funds expended on the problem.

Sincerely,

Harold A Swift

Harold A. Swift, ACSW
Administrator

Enclosure

Senator **Durenberger**. Dr. Prud'homme?

Dr. **Prud'homme**. Thank you.

STATEMENT OF ECK G. PRUD'HOMME, M.D., CHIEF OF MEDICAL STAFF AND CHIEF EXECUTIVE DIRECTOR, SHICK SHADEL HOSPITAL, FORT WORTH, TEX.

Dr. **Prud'homme**. Senator, ladies and gentlemen.

My name is Eck Prud'homme. I'm a medical doctor and the executive director of Shick Shadel Hospital in Fort Worth, Tex. Our hospital in Fort Worth is one of three Shick Hospitals. It is a fully licensed and accredited medical hospital specializing in the treatment of alcoholism under the supervision of nonpsychiatric physicians. It is an approved medicare provider.

The Shick Hospitals are proprietary hospitals. The other two Shick Hospitals are located in Seattle, Wash., and Santa Barbara. The Seattle hospital was opened almost 50 years ago. In all, over 35,000 patients have been treated in these three hospitals.

With me today is Dr. Barry Tuchfeld. He is an associate professor of sociology at the Texas Christian University and director of the Center for Organizational Research and Evaluation Studies in Fort Worth. He is the author of a study of major impact and importance in the field of alcoholism and alcoholism treatment. The very first published findings from that study were prepared and filed with this subcommittee.

I strongly urge that this study be considered before you act on the question now before you.

Why is this study referred to so important? It is important for two reasons:

First, any physician or institution that undertakes to treat a disease as serious and deadly as this one has the obligation and the responsibility to scientifically document the manner and degree to which the treatment benefits the patient.

Dr. Tuchfeld's study, conducted with the highest degree of scientific integrity and scholastic independence, is only the most recent manifestation of the fulfillment of this responsibility by the Shick Hospitals.

Second, this study and its findings provide strong evidence that the outcome or result of an alcohol treatment program can be scientifically and accurately measured. This study provides solid data for examining treatment results in many areas of the alcoholic's social life and physical well-being. We can look at changes in not only health but also work and family environment. The results found by this study were quite supportive of the efficacy of the Shick treatment program, it so happened.

Of course, the goal of any treatment of the person addicted to alcohol must be to achieve complete abstinence from alcohol. This is a very difficult goal to achieve. Yet the results of the TCU study show that 60 percent of all patients who completed our 14-day treatment program in 1979 enjoyed at least 1 full year of continuous abstinence immediately prior to the 18-month interview. And it might be of interest to note that the older patient, that is, those over 60, were actually the age group which benefited best from our treatment.

In comparison, there is no independently obtained scientific evidence that I can find that alcoholics utilizing outpatient treatment improve at a greater rate than the improvement that sometimes occurs spontaneously. Now, this is not to say that such programs are not effective or certainly that they may not be appropriate for certain people, it is only to say that we know of no solid scientific evidence at this time of their effectiveness. If there is such, I am very anxious to see it.

It appears that all spokesmen here today agree that treatment of the disease of alcoholism is clearly cost effective. Recognized authorities estimate that alcoholics, including medicare patients, utilize health care services—I guess I should say there "alcoholics in a well-developed stage of the disease" utilize health care services—at a rate as great as six times greater than the nonalcoholic patient.

Considering the cost of present treatment programs—outpatient, inpatient, freestanding, and what not—and the overall utilization of health care services, that is, the overutilization by the drinking alcoholic, it is easy to see that the cost of treatment will be quickly recovered, generally in less than 2 years. I know of no other disease for which such a statement could be made.

The goal of treatment must be abstinence from alcohol. Medical science has shown, and it is certainly our experience also, that as little as one or two drinks can well trigger a return to prior levels of tolerance in drinking in the addict.

In general, there are two ways of attaining abstinence: One is to provide support and encouragement during the slow process of eroding the addictive craving; or, secondly, to medically attack that craving itself. In a truly medical treatment program under the direct supervision of physicians, Shick attacks the addictive craving. This requires a fully-staffed acute care hospital setting. It cannot, in our nearly 50 years of experience, be adapted to a nonhospital setting.

Our program is built around an adaptation of Pavlovian counterconditioning which some call aversion. It is based on well-established scientific principles and has been perfected into a safe and useful clinical tool by 47 years of research and treatment.

By the way, these techniques allow us to accomplish in approximately 10 days at least what others take 20–30 days in general to accomplish.

We combine that treatment with counseling, family counseling, and education so as to fully equip our patient to function happily in a life without alcohol.

Computerized aftercare follow-up systems for a full 2 years have demonstrably increased the effectiveness of the outcome for our patients.

When I began my association with the Shick Hospital in Fort Worth I had very negative expectations about the ability to successfully treat alcoholism. I was immediately astonished by what I observed. These patients were sick in every organ, indeed in every cell of their bodies. Yet, in a very short time I found that many of these people were being made whole again and able to resume a normal productive role in society.

Medicare now covers the treatment of alcoholism basically the same as any other disease, and the cost of this coverage is not excessive—$100 million someone mentioned here. Even if it is $200 million, you are talking about less than 1 percent of the cost of treatment that medicare pays out which goes to treat the third cause of death, certainly of the older group. It goes for the treatment of that 15 percent of the medicare population suffering from this disease.

There may be a very good reason to extend that coverage to nonmedical, nonhospital facilities. This must be finally determined by treating physicians and future research. But if you decide to do so, please do not couple that extension with restrictions on the medicare patient's access to certified hospital treatment that has been proven to be safe, effective, and certainly cost-effective.

Thank you for giving me this opportunity to testify. Of course, I will be happy to answer any questions.

Thank you.

[The prepared statement of Dr. Prud'homme and the Alcoholism Treatment Research Study, follow:]

TESTIMONY OF ECK G. PRUD'HOMME, JR., M.D.

Before the United States Senate
Committee on Finance
Subcommittee on Health

July 20, 1982

Senators, Ladies and Gentlemen:

I am Eck Prud'homme, a medical doctor and the Executive Director of Schick-Shadel Hospital of D/FW, Inc. A copy of my curriculum vitae is attached as an appendix to my written statement. I am submitting this statement to the Senate Committee on Finance, Subcommittee on Health in an effort, among other things, to describe to the Subcommittee the medical treatment of the disease of alcoholism at Schick Hospital and the cost benefits attendant upon the in-hospital treatment of this disease.

Schick-Shadel Hospital of D/FW, Inc. is but one of three Schick Hospitals. It was started approximately ten years ago and now treats approximately four hundred fifty new patients a year in its thirty-four bed facility. It is a fully licensed and accredited medical hospital and an approved Medicaid/Medicare provider. Schick Hospital specializes in the diagnosis and treatment of the disease of alcoholism under the supervision of qualified non-psychiatric physicians.

The other two Schick Hospitals, located in Seattle, Washington and Santa Barbara, California, have facilities for fifty-seven patients and thirty patients, respectively. The Seattle Hospital was opened almost fifty years ago. In all, over thirty-five thousand patients have been treated in these three hospitals. Not only have a large percentage of them been helped by the treatment, the treatment itself has constantly evolved over the years to become an ever-increasingly effective and safe method of treating the disease of alcoholism in about half the time of most other programs. It employs unique, but straightforward, medical techniques, which are combined with intensive group and individual counseling and a well-monitored Aftercare Program. I will describe the Schick Program in greater detail in a short while.

As mentioned, the Schick treatment has evolved over the years. Part of this evolution came from knowledge derived from the day-to-day contact with patients. A large part also was the result of pure research conducted by the Schick Hospital system in the area of the causes and treatment of alcoholism. As mentioned in a letter of Schick's Chairman, Patrick Frawley - a former patient himself of the Seattle Hospital - Schick has spent over six million dollars on research into alcoholism and other addictive behaviors. These research dollars are not funded by any government or private foundation - they come from Schick itself and its affiliates and have not been recovered in the form of profits nor passed through to patients.

I will not elaborate on the specifics of the research done as that will be set forth in the testimony before the Subcommittee of Dr. James Smith of Schick's Seattle Hospital. I will mention, however, that our facility in Fort Worth has also funded studies as to the effectiveness of the treatment for the patients submitted over the period of a full year. The study deals with the former patients' condition at admission, six months after admission and a year and a half after admission. Hopefully, unless the treatment process itself is eradicated by the withdrawal of coverage by Medicare and private insurance, the study will move on to examine the condition of these same patients five years after admission. You will be hearing from the Director of that study, Dr. Barry Tuchfeld of Texas Christian University, as to the results of that study.

A. ALCOHOLISM IS A DISEASE

Before going into either the Schick method of medical treatment or its cost effectiveness, some preliminary remarks are necessary. Some of these remarks might seem overly basic at first blush but they are not. A true understanding of them is required before proceeding further.

First of all, alcoholism is a disease. Twenty years ago, it was considered a moral weakness. Today, it is universally acknowledged as being a disease even though it is not yet accepted as such.

Alcohol, which is a physical destroyer of living cells, is always present in our environment. It is natural for men to drink it, and some eighty percent of us do. Of that eighty percent, one in ten will develop the potentially fatal disease of alcoholism addiction.

If alcoholic means being in trouble from alcohol, then there are two fundamentally different kinds of alcoholics - those in trouble because they have become physically addicted to the drug, and those who are in trouble because of alcohol but who are not addicted to it.

These differ in the cause of their condition; in the destruction that alcohol will directly produce to their bodies and brains; in the kinds of treatment required; the likelihood of spontaneous long-term remission; and the probabilities of success from treatment.

It is important to realize, at the outset, that most of the death, devastation and destruction attributed to alcohol-related conditions is due to physical addiction to the drug. The prevalence of true addictions is indicated by the fact that over 95% of those who come to us for help are physically addicted to the drug ethyl alcohol.

Physical addiction is medically defined as an increased tolerance combined with the occurrence of clinically observable symptoms of distress (termed withdrawal) when the concentrations of that substance in the addicted animal's body decreases. In the case of alcoholism, this is a physio-chemical adaptation to an extremely inimical internal environment. It is a maladaptive adaptation: that is, a biological adaptation with negative survival value.

Once begun, every aspect of physical addiction progressively worsens as drinking continues. The anxiety, suffering and pain which constitute withdrawal inexorably increase in intensity and appear progressively quicker. An inevitable result of this painful progress is the alcoholic's ever-increasing preoccupation with alcohol. More and more of the victim's mental activities unavoidably are diverted toward thoughts of staving off the torments of withdrawal ("When will it be okay for me to get the next drink?"), leaving ever less time for thoughts of wife, family, job and friends.

The primary process in this fatal progression is the biochemical-biophysical changes in all the cells of the body; changes in the cells which permit them to survive, and even to function, in an internal environment consisting of the body's normal fluids plus massive concentration of the toxic chemical, ethyl alcohol. What makes this the fatal disease is that some of those physical changes in the cells which permit this remarkable tolerance are irreversible. In short, alcohol addiction, as distinct from alcohol abuse or problem drinking, is a grave, progressive, physical disease which is generally fatal unless arrested by permanent abstinence, and I do not mean mere detoxification.

Detoxification by definition is the process by which the addicted body somehow reverses its physical dependence upon the drug,in this case, ethyl alcohol. The act of detoxification is a simple, although often painful, process for the patient. Five days without ingestion of alcohol will normally accomplish it. But detoxification alone is not enough. The disease of alcohol addiction displays a persistent tendency to relapse even after physical dependence has been reversed.

The mental preoccupation with alcohol persists long after the physical dependence has been reversed and powerfully predisposes the victim to suffer a relapse. Effective treatment must be directed toward mitigating this all pervasive preoccupation or craving. Thus, the crucial goal of any alcoholism treatment program must be the preventing of relapses by eradicating this overwhelming desire for alcohol.

B. THE COST OF ALCOHOLISM

I had intended to address briefly the cost to society of alcoholism. Senator Durenberger's comments reported in the Finance Subcommittee's Press Release of July 8, 1982, however, state it succintly:

> Alcoholism and alcohol related problems have resulted in significant costs to our Nation, in terms of human as well as financial resources. It has been estimated that alcohol related problems have had a cost of $28 billion in lost productivity, $18.2 billion in health and medical services, and $7.3 billion due to auto accidents involving drunk driving. Twelve to fourteen million Americans are believed to be struggling with an alcohol problem and the

> American Hospital Association estimates that approximately one-half of all occupied beds in the United States were filled by people with ailments linked to the consumption of alcohol. It has been estimated that as many as 15 percent of the elderly population, the primary recipients of medicare benefits, are believed to suffer from alcoholism. The Health Care Financing Administration, in fiscal year 1979, estimated that the medicare program paid about $100 million for the treatment of alcohol-based disorders and alcoholism.

It is estimated that sixty percent of all crimes of violence are committed by people under the influence of alcohol. The cost of convicting and incarcerating those thousands each year whose crime may well have been a symptom of a fatal disease is usually overlooked when the cost alcohol extracts from society is added up.

C. THE SCHICK PROGRAM

Summarizing the above, it appears that alcoholism is a progressive disease, destroying the lives of many of our citizens and squandering a large portion of our nation's productivity - it is physical in nature. Mere detoxification is not enough. The ever present threat of relapses must be thwarted. How can this tendency to relapse be reduced?

There are really only two ways of approaching this therapeutic challenge. The first basic method is initially to isolate the patient from the drug, thereby allowing time slowly to erode the patient's preoccupation or craving, which is necessarily largely beyond his or her conscious control, while providing support and encouragement in an attempt to enhance the patient's motivation.

Many proprietary hospitals and free-standing non-hospital facilities basically follow this program, and usually utilize AA during and after their treatment programs. To be effective, this method seems to require that the patient be able to interact effectively in a group setting and that he be able to set aside about twenty-eight consecutive days after physical detoxification. Many Veterans Administration programs follow this model, except they often extend the initial treatment period to forty-five consecutive days or more. Of course, the more days required for treatment, the more expensive the treatment becomes and the more reluctant the patient becomes - especially the beginning alcoholic still holding down a job - to disappear from his work for such an extended period. Other federally financed treatment programs attempt to follow the same basic treatment method by having detoxification in a hospital setting, when needed, followed by a few days of in-patient, non-hospital counseling which, in turn, is followed by out-patient counseling.

Another form of this approach is the psychiatric model. It completely ignores the reality of physical addiction and assumes that alcoholism is merely a symptom of some psychiatric illness, and asserts that, once that psychiatric illness is controlled by four weeks or so of treatment by a psychiatrist in a psychiatric hospital, the symptom, alcoholism, will somehow fade away. This is expensive but, compared to the cost of not adequately treating the disease, not excessive if it were effective. The problem is, there seems to be no statistically or scientifically acceptable evidence that it is very effective for most patients. While some patients need psychiatric treatment, physical addiction is neither a psychiatric disease, nor a symptom of a psychiatric disorder, nor does physical addiction itself have a classical psychiatric treatment.

Of course, a non-psychiatric treatment program can be housed within a psychiatric facility. However, the interaction [illegible] patients is vital to any treatment of alcoholism - so vital that any dilution by the presence of non-alcoholic patients is [illegible] detriment to effective therapy. This means that if an alcoholism program is housed in a psychiatric or an acute medical-surgical hospital, it must really be isolated from the rest of the hospital.

The other method of treatment is the one developed at the three Schick-Shadel Hospitals over the past forty-seven years. It is designed to accelerate the extinction of the alcoholic's preoccupation with alcohol, thereby substantially decreasing the possibility of relapse. Schick's hospital treatment [illegible] medical in every sense of the word and it is intensive. For [illegible] our Hospital is functionally full at a census of twenty-six; [illegible] twenty-six patients we must maintain a staff of twenty-two to twenty-four licensed nurses. Our treatment is based upon well-established scientific principles and has been perfected by [illegible] careful clinical observation and independent evaluation of results.

It consists of the following:

1) full medical detoxification when indicated;
2) Pavlovian counterconditioning;
3) narcotherapy;
4) daily individual counseling;
5) group therapy;
6) intensive education;
7) family therapy; and
8) effective two-year aftercare and follow-up which may include AA and/or Antabuse.

A brief description of each procedure might be of assistance to the Subcommittee.

1) Detoxification

I outlined the concept of detoxification earlier. Depending entirely upon the stage of the alcoholic's disease, detoxification may range from a minor inconvenience to a medical emergency. However, all agree that however severe the disease and regardless of what treatment is to be used, treatment of the primary disease of alcoholism and its addiction cannot begin until detoxification has been completed.

2) Pavlovian Counterconditioning

Impressed with the obvious similarity between the automatic behavior which results from Pavlovian conditioning, and the apparently automatic resumption of drinking which characterizes alcoholism, a layman named Charles Shadel and Dr. Walter Voegtlin, who had known and worked with Dr. Pavlov, set out to see if specific treatments, designed to extinguish Pavlovian-conditioned reflexes, would help detoxified alcoholics avoid relapsing into drinking. To test this, they designed a simple experiment that could have been taken from a Psychology 101 laboratory experiment.

In a setting replete with alcohol-related visual stimuli, the patient was presented various alcoholic beverages. The seeing, pouring, savoring, smelling and tasting of alcoholic beverages was repeatedly coupled with an unpleasant sensation. In the early work at the Shadel Hospital in Seattle, nausea was the unpleasant sensation with which the sight, smell and taste of the beverage alcohol was associated. As theory predicted, the patients lost their desires for alcoholic beverages, nearly eliminating both their preoccupation with and therefore their craving for alcohol. In fact most patients very quickly developed an active distaste for, or even an aversion to, the sight and especially the smell of ethyl alcohol, no matter how it might be masked.

Much of the improvement made over recent years in the original techniques has been in increasing the length of time the counter-conditioning remains effective. This extension of the time during which a patient remains conditioned against alcohol was obtained in several ways, such as by adding free days between treatments (later sleep therapy was added on these free days), by increasing the number of aversion treatments to five extended over ten days of hospitalization; and by adding two reinforcement treatments, of two days each, at one and three months after the initial treatment was complete. The procedure when done repeatedly and properly returns to the patient the ability to make the choice of whether to drink or not in a far more meaningful way than he was able to do before. What our patients repeatedly report to us when they return for reinforcement treatment is how grateful they are that the constantly recurring thoughts about alcohol are no longer in their minds.

3) Narcotherapy

The narcotherapy treatments (or sleep therapy) were derived from the "pentothal interviews" then being used by some psychiatrists. In low doses the rapidly-acting hypnotic drug, pentothal, sometimes called "truth serum", was given by slow intravenous drip. The patient would be interviewed as he slowly drifted off to sleep. As time went by, this procedure was modified to meet the treatment needs of alcohol addicted patients.

Narcotherapy plays a number of important roles in our program. First, since alcohol, when at blood levels typical of addiction, blocks sleep, and since months of abstinence from alcohol are required for the return of normal sleep patterns, our patients need rest. Besides being physically restorative, the narcotherapy proved a good counter-balance to the aversion treatments. Without realizing it, our patients are "learning" to look forward to the non-alcohol days. This positive reinforcement is important to our treatment.

Secondly, by simply offering the patient a drink as he drifts to sleep, we can test the effectiveness of his aversion to alcohol at that time. If the patient accepts, or requests a particular drink, we know we must do more work. These interviews are taped and given immediately to the patient. It is also reassuring to the patient when he hears himself, without a moment's hesitation, refuse his favorite drink.

Thirdly, denial is a part of every serious chronic disease. No one wants to accept the fact that he is sick, that he is different and especially that he always will remain different from everyone else. Denial in this disease is often very great, and it must be completely broken before any treatment can succeed. If a patient leaves with even a subconscious notion that "a little wine with a meal cannot hurt anyone", then, no matter how strong his willpower, he will relapse.

Narcotherapy interviews can help us break this denial in stubborn cases. When the patient hears herself describing under pentothal how much of her time she spent in getting alcohol, drinking it, hiding it, covering it up and living with the fallout from drinking, the repeated contentions that she only has a couple of glasses of sherry at bed time, "because her doctor forces her too" becomes less tenable. This, combined with the interaction with our other patients and especially with those returning for reinforcement and even for relapses, usually enables us to dent, if not to break, that denial.

Fourth, while we do not probe deep into the past, nor into dark psychic recesses, these interviews often enable us to identify much more quickly than we otherwise could, problem areas that either must be worked with by our psychologists, counselors and physicians or referred to other specialists for appropriate follow-up therapy.

Fifth, the tapes recorded during this therapy, when shared with family members, often serve as catalysts in assistng patients to re-establish, or sometimes establish for the first time, communications with those they love. This can contribute importantly to another treatment component - family therapy or involvement.

Finally, as most patients listen to their tapes after returning home, planting good advice on the tape is a way of insuring that the patient will be reminded, almost subliminally, of suggestions we hope will be helpful. This aids the educational component of treatment.

4) Individual Counseling

The goal of individual counseling is to identify special problems unique to each patient which must be dealt with either here or by referral after dismissal. Also, helping the patient to look realistically at his life is essential to the breaking of denial. Obviously, our counselors must work closely with the therapists who administer the narcotherapy interviews and with the aftercare specialists in assisting the patient to make realistic plans for a sober future.

5) Group Therapy

This is a time-honored way of assisting patients to view themselves and their situations realistically and positively. This can help break denial, identify problems and assist in education. Additionally, Schick uses group therapy to reinforce individual counseling and to provide the patient with motivation. Often the group therapy also provides the alcoholic with his first realization that there are millions of others who have the same problem that he has. This often helps to negate the inner feelings of shame that sometimes block recovery.

6) Education

Education is an essential part of the effective treatment of any chronic disease. For one with an acute disease, for example pneumonia, it is only necessary that the patient find a competent doctor who will prescribe the best medication. In a matter of days the patient will be well or dead, quite independently of his knowledge of the particular bacteria that caused the pneumonia. Alcoholism is different, partially because of the stigma attached to it, and particularly because recovery from alcoholism requires a patient's cooperation twenty-four hour a day.

To cope successfully, over a lifetime, with a chronic, persisting disease, the patient must understand the essentials of what has happened to him with the addiction and what is happening with him in the recovery.

7) Family Therapy

Certainly this is a family disease. Every chronic and slowly progressive fatal disease is - but especially those diseases such as alcoholism and slow-growing brain tumors. These types of diseases produce marked derangement and variability in all mental processes, including moods, personality and the ability to respond normally to family situations. Of course, the return of reasonably normal family relationships can forcefully reinforce the patient's conscious determination not to drink. Whenever possible, family members take part in both morning and evening group sessions. They have some individual counseling sessions either in person or by telephone and are strongly urged to take an active part in the patient's aftercare program. This may include accompanying the patient to Schick aftercare groups and possibly becoming involved in Al-Anon or Alateen. The families' sharing of the taped narcotherapy interviews is often beneficial in stimulating real communications within the family.

8) Aftercare

Very early in our program's development, our professionals recognized the importance of aftercare, or follow-up, in the treatment process. In fact, Schick's program of having patients return to the hospital for the two reinforcement treatments at one and then at three months after the initial treatment cut our relapse rate just about in half.

A spinoff of the research project of Texas Christian University (in which Dr. Tuchfeld and his staff traced many aspects of the lives of our patients for six and eighteen months following treatment) was the creation of a highly-effective, computerized aftercare system. Regular contacts by phone are made by our aftercare counselors for two years after treatment. In these contacts, the patient is constantly encouraged to continue his aftercare program, including the reinforcement appointments. The aftercare counselor usually develops a rapport with the spouses of the patients, even in cases where the spouses could not come to the hospital. This assists in returning the family to normal, supports the recovering patient, identifies situations where the recovering alcoholic might be building himself up to a temptation to drink and very often discovers relapses at a very early stage and gets those relapses back for short-term retreatments very soon after the relapse has occurred. It must be remembered that we are dealing with a chronic relapsing disease. Often, how quickly and well we can deal with the relapses is just as important, both economically and therapeutically, as is the initial treatment. Schick maintains weekly aftercare group sessions for its graduates and their families. These are led by counselors and are without charge. Such groups are operating in our hospital in Fort Worth and in Houston, San Antonio and Dallas.

After our computerized aftercare became operational, the percentage of those completing the two reinforcement treatments increased, as did the number of relapse treatments. More importantly, when relapses did occur, the time between the resumption of drinking and the beginning of the retreatment decreased, thus increasing the chance for a successful retreatment.

Some confuse the use of the drug Antabuse with Shadel's "aversion" techniques. Antabuse is a drug which, when taken hours before, will cause one to become ill after drinking alcohol. Some have tried giving patients Antabuse and then having them drink alcohol to become ill. This is not effective as a counterconditioning technique because the illness comes after, not simultaneously with, sight, smell and taste of the beverage alcohol.

All the taking of Antabuse can do is to reinforce the patient's conscious determination not to drink. It cannot decrease the preoccupation with or the craving for alcohol. It is not a part of our treatment, but our physicians may prescribe it, as an additional tool for maintaining sobriety after treatment, for approriate patients who request it. Our studies show taking Antabuse has little effect upon the outcome of our treament.

Patients come to us to receive serious medical treatment of a very serious medical condition. After any necessary detoxification, each patient's day begins with breakfast followed by one hour of a rather didactic group session on such topics as the "Physical Aspects of the Disease of Alcohol Addiction," "Tools for Coping with Stress and Despair Without Resort to Chemicals," "How to Be Assertive, Not Aggressive," "The Quest for Spiritual Comfort"; then either a counterconditioning or narcotherapy session as described above, which takes from two and one-half to eight hours, which is followed by a rather typical group interaction session in the evening.

The goal of therapy of physical addiction (termed the gamma type of alcoholism) must be permanent abstinence. The normal American life includes taking a drink upon occasion. We must somehow cause, help or enable the alcoholic to live and enjoy life without drinking. We neither demand nor expect perfection from other humans, why demand it of victims of this disease - the very people we are so prone to label as weak-willed? We tolerate less than a thousand batting average in professional baseball players, but not in the alcoholics who must decide at least seven, or is it seventy or seven hundred?, times each week whether to drink or not to drink. When out of thousands of times he finally makes one wrong decision or, more to the point, he simply hesitates before making a decision, allowing the habits of a lifetime and the dictates of society to determine his action, and takes a drink, a fatal disease is reactivated. And we, both medicine and society, compound the agony of relapse by condemning him as weak-willed - as if his guilt needed exacerbation.

From the time of admission to discharge, our patients remain in hospital pajamas. We issue no passes. Experience has shown that when patients leave the hospital setting for even a part of an occasional day, the interruption is definitely detrimental to their chances of a successful outcome. To be successful in helping our patients completely change their lives, the way they accept themselves and others, and the way they view what is important, we must have them physically in the hospital for the full ten days. The treatment we have found most effective and expeditious, after more than thirty-five thousand patients and forty-seven years of trying, is simply not adaptable to an outpatient setting.

This is not to suggest that all people with alcohol problems need this particular type of treatment, nor that all effective treatment methods require a full hospital setting. Others must address these questions.

D. COST EFFECTIVENESS OF TREATMENT

As mentioned previously, Senator Durenberger estimated that Medicare pays up to $100 million dollars a year in connection with alcoholism-related treatment. No one can reasonably say that this is not a great deal of money. However, I must tell you that, rather than adding to these high expenditures, Schick Hospital's treatment program actually saves Medicare funds each year.

Let us consider the care of a sixty-five year old patient with moderately advanced alcoholism. This patient's life expectancy, if he or she were free of the disease, would be roughly seventeen more years, or to age eighty-two. With the disease, his or her life expectancy is more likely to be ten years, or to age seventy-five. Why is there such a marked difference in life expectancy?

Simply stated, uncontrolled alcohol addiction increases the rate of aging. By this I mean, alcohol addiction and the maladaptive physical changes in the body's cells which produce addiction cause the body to age prematurely. Generally, alcohol addiction will, on the average, kill the alcoholic in thirty years of progressive drinking. Typically, unchecked alcohol addiction deprives its victims of about fifteen years of life. It also makes the remaining years much more expensive medically.

For example, on the average, an alcoholic incurs health service costs at a rate six times as great as that of a non-alcoholic of the same age and sex (from Statement of W. P. Daves, Jr., Chairman of the National Association of Insurance Commissioners Task Force on Alcoholism, Drug Addiction and Insurance). If we estimate that the normal person sixty-five to eighty-two years of age incurs Medicare costs of $1,500 per year, we see that without treatment the drinking alcoholic on Medicare from age sixty-five to his expected death at age seventy-five would cost Medicare $90,000 compared to $25,500 for the non-alcoholic who lived to age eighty-two.

Schick Hospital's treatment costs approximately $8,000 with a 59.3% chance of the patient attaining good sobriety. Dr. Tuchfeld's study indicates that the Schick success rate in helping alcoholics over the age of sixty-five is even higher. Assuming, ultra-conservatively, that treatment is successful in only one out of three cases, then the the total net cost to Medicare of treating a sixty-five year old Medicare patient at Schick can be estimated at:

$8,000 (cost of treatment for each of three patients) x 3 = $24,000

17 years of life expectancy x $1,500 (normal health cost per year) = 25,500

Total Cost to Medicare to Life Expectancy = $49,500

Even if we assume, because of a retreatment and some extra health costs resulting from the patient's prior drinking, that the average health care consumption of the non-drinking alcoholic would average twice that expected of a non-alcoholic of the same age and sex, the total cost to Medicare to the patient's life expectancy would be:

$8,000 x 3 = $24,000

17 years x $3,000 = 51,000

Total Cost of Medicare to Life Expectancy = $75,000

This is still less than the estimated $90,000 cost to Medicare if the patient is not treated. Of course, if, as the referenced study shows, nearly sixty percent of those over sixty-five stop drinking rather than just one in three, a real savings is possible.

The dollar savings from Schick Hospital's treatment are large because of the nature of the disease itself. Alcoholism is among the most chronic of fatal diseases. Typically, alcoholism takes approximately thirty years to kill the alcoholic. During at least half of those years, the alcoholic consumes health care services at a greatly accelerated rate. In fact, since alcohol addiction is a progressive disease, the rate at which an alcoholic consumes health care services constantly accelerates.

Those private insurance carriers who have already used every conceivable subterfuge to strip their insured of adequate coverage for this disease will save money only if all alcoholics were denied access to medical services for the many medical problems that occur because of their alcoholism. These short-sighted carriers are not removing coverage from most of their alcoholics, they are simply delaying coverage.

That alcoholism takes so long to kill is the reason successful treatment of it can be so cost effective. Even if only direct health care costs are considered, it is cheaper over even the medium term of two to three years to treat alcohol addiction than not to treat it. I know of no other disease about which such a statement could be made with anything near the same degree of certainty.

I can assure you that you will find that alcohol addiction falls well within that group of diseases to which medical resources should not be denied, nor seriously curtailed. This is true regardless of the possible criteria used to weigh the need for Medicare benefits:

1) _net_ cost to the Medicare system;

2) cost per year of added life; or

3) cost per year of added healthy life (_i.e._, sobriety).

The figures contained in Senator Durenberger's Press Release need little elucidation to make this point.

The disease of alcoholism costs $18.2 billion a year in extra health and medical care. The only way to reduce this hemorrhage of funds and medical resources is to reduce the number of persons suffering from the disease of alcoholism. There are but two ways to do this: prevention and early treatment of the primary disease. Medicare is allocating nothing on prevention, and is spending only $100 million on treatment of a disease which the American Hospital Association estimates is largely responsible for the utilization of about one-half of all hospital beds in this country.

I hope that each member of this Subcommittee realizes that if health resources must be rationed there is absolutely no justification - medical, logical, social, or financial - for discriminating in any way against the medical disease of alcohol addiction.

There is a tendency to presume that most alcohol-related problems are due to ordinary people who, upon occasion, just happen to, or allow themselves to, drink too much. This is an unjustified, undocumented and extremely dangerous presumption. Some responsible for alcohol's record of death, destruction and devastation are simply abusers of the drug. But, as judged by the fact that of those who come to us for help, over 95% percent are unequivocally physically addicted to the drug, most of those who commit the 50% of all crimes of violence attributed to alcohol, and most of the 20% of all automobile deaths which are alcohol-related, and probably half of all suicides are committed by people who unequivocally are physically addicted to the drug. In short, most of such statistics of horror quite literally are symptoms of the fatal disease of alcohol addiction.

Confirmation of this important point comes from a recent study done by the University of Pittsburgh in which blood alcohol levels were run on all patients seen in the emergency room of a community hospital for minor cuts and sprains with no legal implications. All admitted to drinking just prior to coming to the emergency room, but were judged by the medical staff as being not intoxicated. The average blood alcohol level of these medically certified "non-intoxicated" people was .268% - more than twice the legal blood level for drunkenness. (The range was .120 to .540% BAL.) This does not mean that the legal level of drunkenness is too low, it means that many people who drink are so clearly addicted to the drug and their bodies have built up such a tolerance that they can act normally after having consumed enough alcohol to make a non-addicted person very drunk. It is clear that improved treatment and/or prevention of this disease is the only conceivable way of rendering a profound service to the suffering of this nation and by so doing to reduce significantly the cost of living, including total governmental expenditures.

Senator Durenberger's Press Release alludes to the present variances in coverage of this disease provided by private insurers. That allusion creates the fear that this Subcommittee may be contemplating some of the devices some carriers have introduced, mostly during this year, in an attempt to deny adequate health coverage to victims of this one disease. Each device is easily shown to be short-sighted and patently and arbitrarily discriminatory against patients suffering from this one disease. They include:

1) attempting to force fully certified medical hospitals to build and man, on a 24-hour basis, surgical operating suites for which they have absolutely no use, if they are to be allowed to continue to medically treat this medical disease;
2) the requirement that the same medical specialty hospitals hire full-time psychiatrists, for whom they have only an occasional need, if they are to be allowed to continue to medically treat this medical disease;
3) some carriers simply exclude this one diagnosis by name, whether directly or by defining any certified hospital as a non-hospital if it treats the primary disease of alcoholism; and
4) other carriers claim to cover the medically indicated need for medical treatment of this medical disease while arbitrarily defining the disease as one which stops with detoxification. After detoxification, they decree no medical treatment is needed. They offer no justification for this contention, which itself is an outright repudiation of the disease concept of alcoholism.

Nearly every insurance carrier which covers alcoholism places restrictions on the length of treatment covered, the dollar amount covered, or even the:

1) geographic area where treatment can be received;
2) type of treatment they will cover; and
3) number of times in a year, or a lifetime that one can receive treatment.

Few of these restrictions are placed upon other diseases.

And lastly, in those states which have enacted the National Association of Insurance Commissioners "Mandatory Optional Coverage" of alcoholism, some carriers are actually using that well-meant effort on the part of state legislatures to decrease the number of people who have any access to medical and non-medical treatment of this disease and to increase, unconscionably, the price of coverage of alcoholism far beyond any possible actual cost to those who do get such coverage.

Of course, any hospital can improve its efficiency and improve its methods of screening for admission. Many others can do what we are doing, in documenting and validating the outcome of our treatment and correlating that outcome with the characteristic of the patient and the type and stage of alcoholism exhibited at admission in order to screen out those with little possibility of success. However, there is nothing we providers are doing, or not doing, which is deliberately, exorbitantly and mindlessly as wasteful as the demands by carriers that medical specialty hospitals operate unused surgical suites, and hire unused, highly paid psychiatrists. Such irrational demands by carriers upon providers can do nothing but escalate costs.

The availability of Medicare benefits for effective, responsible programs for the treatment of alcoholism can be extremely cost effective to the Government and a model for private insurance carriers. Denial of such benefits may very well also become the model for private insurance carriers and effectively sound the death knell for proven dedicated and effective treatment programs such as ours.

Senator DURENBERGER. Thank you all very much.

I think what I would like to do in the time we have available to us is to concentrate on what incentives there are for effective treatment and for minimizing the cost of that treatment. How can we build our confidence level in whoever it is that has to make the decision on our behalf?

There is a thread of testimony in each of the presentations that the basic responsibility for diagnosing alcoholism and recommending the most appropriate treatment is a judgment that might best be left to providers. Clearly, the present system doesn't even permit the provider to make the most cost-effective judgment.

It would be helpful if each of you might comment in terms of how best we consider changing the current reimbursement system so we can have confidence that all the right incentives are in all the right places, both with regard to the effectiveness of treatment and the cost of treatment.

Mr. MCELFRESH. Well, I think you are right. It is a very difficult question, because for the most part we have not been faced with that. My feeling, however, is that we cannot continue the way we have in the past, and I don't think that the alcoholism field should be the recipient of the whims of everyone else. And I think it is probably the providers responsibility at this point to take the responsibility from an integrity standpoint, if for no other reason, and to begin to take a look at, at least from where I come from, the stance that there are a variety of levels of care that patients should be sorted into depending upon the severity of their illness. And right now that is not being responded to positively by very many third party reimbursers.

For example, we sometimes have to argue with people about why they ought to be in a residential nonhospital facility versus a hospital facility, because some have the crazy idea you are going to get better care in a hospital.

We also have referral resources say, "We will not cover your primary outpatient program. We'll cover 3 or 4 weeks inpatient at either residential or the hospital setting. "So I think it is an integrity question on our part, at least from where I see it. I feel, and we feel at Lutheran, that we need to get better at more clearly diagnosing and more clearly identifying the extent of the illness as well as that group of patients that traditionally have not recovered in our programs or with Alcoholics Anonymous, and the constant recidivists, to take a look at who is that person? What is it that's not happening with this individual?

One of our beliefs is that this person probably has concurrent psychiatric illness along with the alcoholism and that they need to both be diagnosed and both be treated.

Senator DURENBERGER. It seems to me that someone should be at risk for failure, too, both in the diagnosis and in the treatment. At least it would be to my advantage as the third party payor to find some kind of a system in which you as a provider are put at some financial risk. I don't know what that is.

Dr. PRUD'HOMME. It is really, I guess, easier for me to answer. I am a physician; I'm treating a medical disease; I'm treating, in the end, what has to be a medical hospital. So my approach to this—I was in general family practice for 25 years before I entered this specialty, or whatever it is—I have to use the same criteria for determining whether a patient should be admitted to this hospital that I used for 25 years with all those other thousands of diseases that I treated.

I realize that is evading your question. If you would like, one thing that we found important, useful, in cutting down on the old revolving door thing is we set up an extremely rigorous aftercare plan. This may include visits to our aftercare facilities, even to AA, whatever. It is closely monitored. Patients who follow that treatment program and relapse, we feel and everything else indicates that they may profit from retreatment. Those people are just as eligible for being retreated as is a diabetic who has a second coma. It does recur. We are dealing with a chronic, progressive, recurring, relapsing disease.

The patient, while he is sober, is responsible for his actions. If he follows through on his aftercare program and still relapses, that patient, certainly in my view as a physician, is entitled to retreatment. If he refuses to follow or does not follow the aftercare and relapses, then he has no access to our treatment.

Now, this again is evading the issue. He can go right next door, of course, and start the whole process over.

ANSWERS TO SENATOR DURENBERGER'S QUESTIONS

There are but two ways to establish cost effectiveness.

(1) First determine the "effect" of treatment and then try to determine the net cost of treatment which is the actual cost of giving the treatment minus any decrease in cost of direct health care which can be attributed to that treatment. From the ratio of (total net cost)/(total effect) one gets an estimate of the dollar cost required to produce a "unit" of improvements for one with that type and stage of the disease.

It is very expensive to follow adequately each person treated over even two years, and to correlate those findings with the same person's condition before treatment. This could not be done by HCFA without increasing the $250,000 presently authorized for "evaluation".

(2) But what HCFA should be able to do at small cost is to determine the actual health care consumed (or that portion borne by Medicare) by each person admitted to each facility taking part in a demonstration before and after treatment. Actually all the necessary data will be in Medicare's computers, it would only be necessary to divert the file of each person upon admission to those treatment programs into a separate computer file where it would be possible to pull out the pre and post treatment costs expended by Medicare upon that person. There is no theortic reason, and no obvious practical reason, this could not be done. It will require computer expertise and a committment to do it. It might necessitate dropping some of the seventy-five facilities from the study but that would be more than made up for by the fact that what data was obtained would be of real use to all concerned with the true cost of treatment this devastating disease. While the quality of health care consumed is but one measure of the severity of this disease it is one of the most objective.

The Kaiser-Permanente HMO people have already done this for their patients with useful results which are readily accessible in the medical literature, *(See American Journal of Public Health, June, 1982, Vol. 72, No. 6, pp. 600 and Alcoholism and Clinical Experimental Research, Vol. 5, No. 4, pp. 497, 1981).

If any comparisons of relative cost effectiveness between different modes of treatment are to be made documentation of the severity, the type and the stage of disease being treated by each mode must be made and all modes of proven safety and effectiveness must be included in the "demonstration". The Schick Shadel Hospitals are willing to participate and have volunteered.

Senator **DURENBERGER**. Harold?

Mr. **SWIFT**. Senator, I have had some experience with third party payment in the private sector developing criteria and determining reimbursement. Criteria on paper are fine. When it gets to the interpretation of that criteria by a given clinician, you get all kinds of judgments about what is medically necessary. And then the provider is at a disadvantage.

I'm not sure, in all good conscience, I would trust providers to be the sole judge of what is necessary and what the price should be. They, too, can have a biased viewpoint even when they are trying to be conscientious. Again, I would look to the competitive marketplace, that we have consumers.

After the Government, the second largest purchaser of health care is private industry. And private industry doesn't have access to what it costs for treatment of alcoholism here versus there, or surgery here versus there. So if we can, again, provide the consumer with some informed knowledge about the cost, including the citizen, and give them incentives to participate in that cost—the lower the cost, the greater the incentive to that purchaser in the form of a company or the individual citizen.

Senator **DURENBERGER**. One of the things that troubles me as I listen to testimony this afternoon is how coverage for alcoholism treatment can be made consistent with a more competitive health system. As we move in the direction of a marketplace, with a choice made by relatively enlightened consumers and incentives for providers to behave cost-effectively, we will increasingly rely on physicians to make appropriate resource allocation and referral decisions. And I am saying to him if he can keep me healthy, he gets rewarded. If he can by appropriate treatment at the right time and the right price, he also gets rewarded.

I have been left, though, with the impression that with regard to alcoholism the medical profession in general is not very well equipped to make some of those judgments. Most of the time my access into that system, if I have the problem, is either through some other disease—as Mr. Mills said, he had high blood pressure—or it is my friends descending on me one morning and plopping me into what they think is an appropriate treatment center.

Harold, can you comment on that?

Mr. **SWIFT**. I agree, Senator. In some of the prepaid medical plans where there is an incentive built in for the providers, the alcoholic can go undertreated through misdiagnosis or through the fact that it is easy to divert the alcoholic to "Well, you just go over to that little program over there." And the alcoholic will choose the least restrictive thing—"I don't want to go away for 30 days; let me have the $10 program." So in some of the prepaid programs there is underservice to the alcoholic.

Senator **DURENBERGER**. Are there any other comments along that general line?

Let me ask you another related question, then. Are you all familiar with the demonstration proposal by HCFA and do you think it is a good idea to spend a few more years trying to come to some conclusions about how best to reimburse in this country?

Dr. Prud'homme?

Dr. **PRUD'HOMME**. I have had considerable contact with that HCFA demonstration program. I have talked to the people at NIAAA, I have talked to the people at HCFA. All I can see that they are demonstrating is that it is cheaper to render some kind of a service by nonnurses, nondoctors, than it is by doctors and nurses. We know that before they undertake the project.

I have talked to them. They have no outcome criteria, was the statement that I got from them at their office. Well, obviously, if you treat 10 people and only one gets well, it really becomes irrelevant. If none get well. They show absolutely no concern about whether there are any effects. You are attempting to demonstrate cost effectiveness when you are making no effort to determine the effect. Utterly meaningless.

I might also say it's designed to set up comparisons between different programs, when most programs are not even included in their demonstration project. If their results mean anything, there is no specialty hospital included among any of those demonstrations, for example.

Dr. **TUCHFELD**. Thank you. I was on the review panel for the HCFA project, and theoretically that endeavor could have a great payoff for the kinds of questions that you are delving into. I think the way you are delving into them deserves a compliment.

On the other hand, there is reality. I believe that the answers that you will finally get from that endeavor will be far less than satisfactory to the kinds of questions, to the complexity of the kinds of questions, you are addressing.

Mr. **SWIFT**. I agree with his comment, Senator. That study may produce nebulous results, and it may even make the nonhospital providers look more expensive than we already know them to be in fact; but they are having trouble coping with the mechanism and the reporting systems.

Mr. **MCELFRESH**. Once again, I am more concerned about the diagnostic criteria coming in, in terms of who do you put where and why do you put him there? And then take a look at results. But if you just throw everybody into the same barrel, then I don't think we are treating the complexity of the illness.

Senator **DURENBERGER**. As I recall, Ms. Feinstein testified that, "Well, they only had so many dollars, so they could only do so much." If any of you have any advice on how HCFA should proceed or not proceed on its demonstration—perhaps with the same number of dollars but something more practical—we would be happy to make it part of the record. If there is a way to better design the demonstration or speed up the results so that we can better make reforms it would be helpful. With regard to medicare, we are moving fairly quickly toward a prospective reimbursement system. I am sure we will be addressing prospective reimbursement next year in this committee, and I would certainly welcome the opportunity to address changes in reimbursement for alcoholism treatment at that same time rather than waiting until we have of hearings in 1983, 1984, or 1985 on this subject.

Thank you all very much. If we have any other nitty-gritties, we will send them to you in writing and ask you to respond.

[Answers from Eck G. Prud'homme, Jr., and Harold Swift to questions from Senator Durenberger follow:]

STATEMENT OF ECK G. PRUD'HOMME, JR., M.D.
CHIEF OF MEDICAL STAFF
SCHICK SHADEL HOSPITAL OF D/FW, INC.

The Honorable David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
Washington, D. C. 20510

Following are the answers for the record to the questions submitted by you under cover of your letter of August 10, 1982.

QUESTION NO. 1:

What has been your experience with the success of people receiving multiple treatments? How likely is it that a person receiving treatment, beyond two prior treatments, will be successful?

RESPONSE:

Our experience is that patients who retreat here once (that is treat here for a second time) do as well or even slightly better than those who treat for the first time. It seems to be a widespread human phenomena that one is often strongly tempted to try to be a social drinker "one more time" because they feel that they are "different from other alcoholics" or perhaps not a "true alcoholic" to begin with. When the patient fails to maintain non-alcoholic drinking and discovers the fallacy of these assumptions, the temptation to again attempt to be a social drinker is dispelled and we experience better results with such patients after the second treatment. Once we get beyond three treatments, our clinical experience indicates that long term success rates begin to drop sharply.

Unfortunately, specific data on the comparative outcomes of treatment for those who have previously treated at the Schick Shadel Hospitals is not now available. The unavailability of this data is due to the fact that the TCU study had to be restricted to new admissions to the Hospital in Fort Worth.

Dr. Tuchfeld's report compiled in conjunction with the TCU Center for Organizational Research and Evaluation Studies, study of Schick patients which was filed with the Subcommittee prior to the July 27, 1982, hearings, does, however, correlate the outcomes of treatment at 18 months after receiving treatment at Schick with the number of times each patient had treated previously at other facilities. See Appendix C.4 of the study. The results as reflected in Appendix C.4 show that there is no correlation between the number of times a patient has treated at another facility and the likelihood of a successful outcome after treatment at Schick.

No matter how this data is broken down the answer remains that there is no correlation of outcome with prior treatment at other facilities. This is true whether the patient treated at one or more other facilities for one or four or even nine different treatments. That patient's likelihood of success after treatment at Schick is the same as a patient who has never had prior treatment at any other facility. This is an unequivocal and important finding that is completely contrary to the "common wisdom" in the field of alcoholism treatment. This "common wisdom" is, of course, that one who has previously received treatment and failed will be more likely to fail at any other treatment of his disease. The acquisition of reliable data refuting such "common wisdom" illustrates well the hazards involved in basing life and death decisions concerning a patient's well being upon such "common wisdom" before that "common wisdom" has been subjected to independent scientific verification.

QUESTION NO. 2:

Do you believe that requiring a person to share a greater portion of the costs for treatment--beyond the initial treatment--would enhance the probability of the treatment being successful?

RESPONSE:

In a word, "No". We find only a very slight and statistically insignificant increased abstinence among patients who pay for their treatment entirely from their own funds (70% abstinence at 12 months) as compared to those patients for whom insurance pays all costs of treatment (63% abstinence at 12 months). We find no difference in outcome between those patients for whom insurance pays part of the cost of treatment as compared to those for whom insurance pays the entire cost of treatment. (These data are from Facts Consolidated, a study of Schick outcomes by an independent survey company. That company used measures of outcome similar but slightly different from those used in the TCU study.

An occasional, especially conscientious, patient might be motivated not to relapse by a threat of the increased cost of a contemplated future retreatment. However, our experience strongly suggests that the patient does not generally contemplate future retreatments prior to relapse. As a result, the likelihood of achieving a desirable effect upon relapsing by increasing the cost of retreatments is very minimal. Whereas the threat of removal of a physician's license to practice medicine or even of the firing of a conscientious laborer may have some effect in helping to cause an alcoholic to continue his or her abstinence, our experience with alcoholics and alcoholism indicates that the relatively minor financial threat of such a policy would have little or no beneficial effect on the tendency to relapse. The result, if any, might only be to discourage the patient from receiving treatment after relapse.

Many Medicare patients have little or no discretionary income. We believe that for such Medicare patients, even a small deductible would be as much of a financial burden (given their usually low income levels) as paying a high percentage of the treatment costs would be in the case of our working patient. In other words, we do not believe that establishing a large deductible feature or co-insurance feature for retreatments would add substantially to treatment success.

We must also remember that Medicare is now paying only part of each hospital's charges in treating the alcoholic patient. As you are well aware, Medicare pays only those costs determined to be "allowable costs". Law prohibits the provider from attempting to recover the difference between its regular charges and such allowable costs from the Medicare patient. This has been at least partially responsible for the cost shifting from Medicare to the private sector which is such an important factor in the rapid increase in hospital charges to all who are not covered by Medicare. Simply adding deductible cost, whether progressive or not, can only then increase this cost shifting.

Such an increase in cost shifting to the private sector will only increase unless the provider of alcoholism treatment is allowed to try to collect the uncovered portion of its charges (or at least the deductible charge) from its Medicare patients. Yet such a system appears on its face to be quite untenable. Medicare only determines what portion of a provider's cost it is going to accept as "allowable costs" well after the close of a fiscal year. Therefore, a deductible charge figured as a percentage of allowable costs would not be available to the provider for collection until well after the patient had received treatment. Rather, any deductible charge would have to be made against a provider's charges rather than the allowable costs if the provider were going to be allowed to try to collect that charge at the time of billing. Of course, adoption of a system of paying a portion of charges, as compared to "allowable costs", will probably increase costs paid by Medicare. Currently, Medicare "allowable costs" run approximately 50%-60% of charges at our Hospital. Payment of 75% of charges, as proposed by Senator DeConcini in Senate Bill S. 1989, would increase Medicare payments by 15%-25% before an attempt was made to collect the deductible from the patient. We feel that the difference would be as much or more at most other alcohol treatment facilities covered by Medicare.

In summary, the results more likely to be expected from the institution of a deductible charge for retreatments would be the following:

1. Denial of treatment to some patients who cannot afford to pay any part of the costs of treatment.

2. Lack of treatment to some patients when such treatment would be cost effective in terms of future health costs for such patients.

3. Exacerbation of the present problem of cost shifting from Medicare patients to all other patients.

4. Very little positive change in treatment outcome.

It therefore seems to us quite certain that whatever immediate decrease in expenses, if any, that might result from discouraging some Medicare patients from receiving medically indicated retreatments of their disease would be largely negated and probably totally offset by the greatly increased consumption of health care costs by those who are prevented from receiving medically indicated retreatment by the institution of a deductible charge.

QUESTION NO. 3:

Any third party payor, including the Medicare program, should only pay for that level of care needed to obtain results. How do we decide what that level is? Are there criteria which can be used to determine whether a patient is being treated in the most appropriate setting, whether hospital, residential, outpatient, or other?

RESPONSE:

Yes, there are criteria to make such a determination, but the criteria of necessity are as complicated as is the disease itself. That many wish to make this disease appear simple in no way diminishes its complexity. It is among the most protean of all diseases with which medicine must deal. It is a grave, progressive internal medical disease which is usually lethal unless controlled by abstinence. At its full flowering, it destructively affects every organ, every cell in the body of the alcoholic. To diagnose it and its various stages and phases and the myriad of complications and concomitant diseases so often associated with it, with the accuracy and completeness necessary for prescribing appropriate treatment, tries the diagnostic skills and acumen of the most experienced physician specialist.

The following categorization of those criteria is entirely operational and non-didactic. It is based upon years of experience in treating these conditions. The diagnostic determinations, which must be made in every case before appropriate treatment can be determined, are as follows:

1. Is there an alcohol problem?
2. Is the patient "alcoholic"?
3. Is he physically addicted to ethyl alcohol?
4. If so, in what stage of the disease is he? and;
5. In what phase of that stage is he?
6. If in Stage III, is advanced Organic Brain Syndrome present?

Then the following diseases and conditions must be diagnosed:

7. Are there significant psychological or psychiatric conditions present which are not attributable to alcohol addiction?
8. Is any other physical addiction present?
9. Is poly-drug use a problem?

10. Is prescription drug abuse a problem?

11. What medical complications of alcoholism are present?

12. What other medical diseases or conditions are present?

13. Is this a professional patient?

14. Is a serious personality deficit present? (Is sociopathy or psychopathy present?)

Other determinations which must be made:

15. What prior treatment has he received in previous attempts at recovery?

16. What prior treatment has he received during this attempt at recovery?

17. What kind of treatment is contemplated for those Phases of Recovery to follow?

From these findings it must be determined for each case which of the following diagnostic categories is most appropriate:

I. NOT ADDICTED TO ALCOHOL

  A. *No Alcohol Problems*

    1. *Professional Patient*

    2. *Non-drinking Skid Row inhabitant* (some simply never developed a taste for alcohol.)

    3. Poly-Drug Users who get drunk on alcohol only in the absence of his favored drugs, and who has not developed a significant increase in tolerance to alcohol.

  B. *Alcohol Abuse*

  Physical addiction is defined as increased tolerance to some effects of a drug combined with the occurrence of physiological symptoms of distress when the concentration of that drug in the addicted animal's body decreases significantly. Alcoholism can be defined legitimately to include conditions which do not entail physical addiction to the drug ethyl alcohol. I call those conditions Alcohol Abuse. So we have:

1. Simple Alcohol Abuse. A typical example is a young male who demonstrates his manhood by drinking a lot and then wildly racing his automobile to show how well he holds his liquor. (It is distressing how many who begin in this category rapidly develop true addiction).
2. Emotional Alcohol Abuse. That relatively rare person who is not addicted but attempts to deal with sadness, loneliness, stress or even pain mainly with alcohol. Though thought common, they are rare.
3. Poly-Drug Use. A poly-drug user is one who only gets drunk on alcohol when his more favored drugs are unavailable and who has not developed a significant increase in tolerance to alcohol.

II. ADDICTED TO ALCOHOL

A. Uncomplicated. There are three well delineated Stages through which the disease inevitably progress once physical addiction to alcohol has begun. Similarly there are three Phases through which recovery progresses once abstinence begins. To this there is no exception. For those found to be physically addicted to ethanol the stage of the disease and the phase of recovery must be ascertained.

The Three Sequential Stages of Physical Addiction to Ethanol

Stage I: Increasing Tolerance to Alcohol

Problems are mostly incipient and easily passed off as indiscretions rather than symptoms of a fatal disease during the stages of increasing tolerance. In fact, early in Stage I the patient is often the toast of his friends precisely because he holds his liquor" so well. By the latter half of Stage I he is beginning to become rather regularly obnoxious.

In early Stage I detoxification (which is the time required for all physical or physiological symptoms of withdrawal to become undetectable) is short and less unpleasant than many non-addicts' hangovers. By the end of Stage I irritability, fine tremors and sleeplessness are present but not severe and detoxification takes about two and one-half days.

Stage II: The Plateauing of Tolerance To Alcohol

This is the stage in which the effects of the years of physical assault upon tissues and organs by high levels of ethanol begin to manifest themselves as medical problems. During this stage, physical destruction at an ever accelerating rate is added to the intellectual, legal, family, job and social deterioration that began in Stage I. Detoxification becomes a progressively more serious medical problem in Stage II. It requires two and one-half to three days for physiological (or physical) detoxification to be completed in Early Stage II, and four to five days by late Stage II.

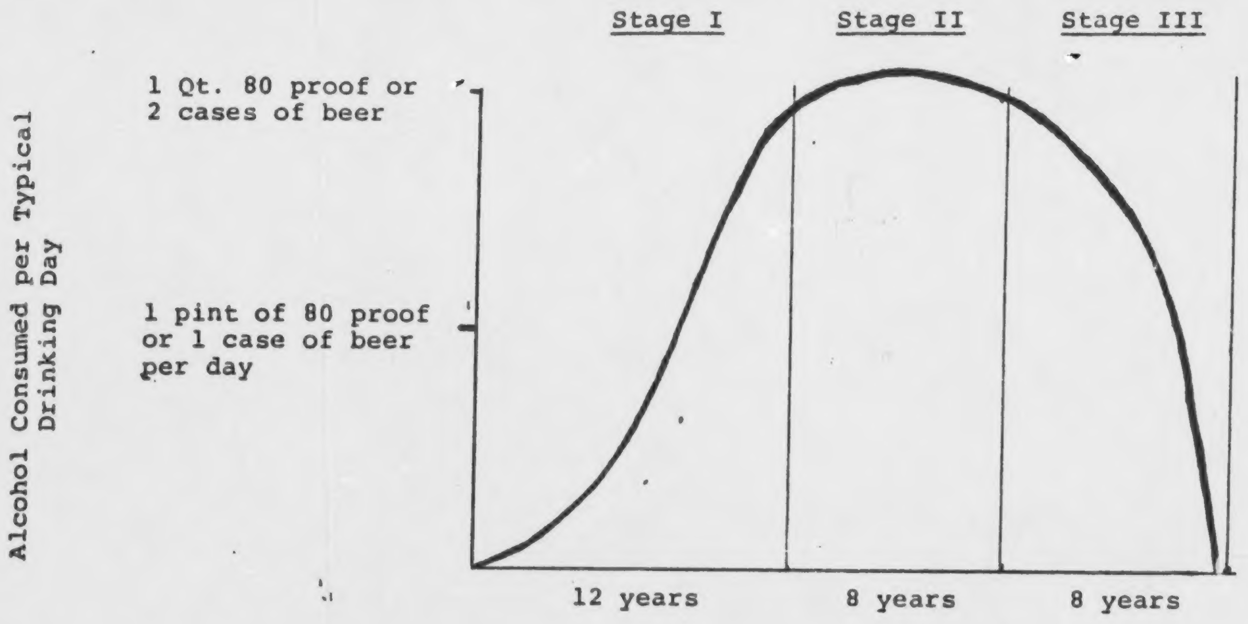
During Stage II the physical symptoms of withdrawal progress rather rapidly in both intensity and duration. The tremor is not only obvious, but by the end of Stage II it is marked. Hallucinations of withdrawal occur only toward the end of this Stage, convulsions are not common and death from withdrawal is rare. Withdrawal is, however, a physically stressful, painful and extremely frightening and unavoidable process in late Stage II.

Stage III: The Decreasing Tolerance to Alcohol.

This is the stage of deterioration. It is literally a race to see which organ will fail first and thereby cause death. Significant physical destruction of the brain will always be present during this stage but the amount of destruction, and apparently the area of the brain where destruction will be greatest, varies greatly and apparently randomly from patient to patient.

In Stage III, physical withdrawal is a serious medical condition requiring hospitalization and occasionally admission to the intensive care unit. Hallucinations are common and true delerium tremens with its associated mortality, still occurs at times. Physical detoxification requires about five days in early Stage III but as long as two weeks in late Stage III.

No matter at what stage of this disease an attempt at recovery is made the recovery process must consist of three consecutive phases.



STAGE I: Increasing Tolerance

STAGE II: Plateau

STAGE III: Decreasing Tolerance or Stage of Deterioration

The Three Phases of Recovery

Phase I: Detoxification.

By definition, if physical addiction is present, a period of withdrawal, or detoxification must occur. Phase I is the time required for detoxification to be completed.

In the earliest stages of alcohol addiction, withdrawal is brief and inconsequential, but by the end of Stage I of the disease withdrawal is a significant medical condition. As the disease progresses, through Stage II and beyond, withdrawal becomes progressively longer and more serious until toward the end of Stage III it is a serious condition -- often a true medical emergency requiring as much as two weeks of hospitalization.

Phase II: Treatment

Phase II is the Phase of recovery during which treatment for the primary physical disease of alcohol addiction must be administered. It is therefore the time during which the true effectiveness of treatment, (or help if the setting is non-medical) is put to the ultimate test. Many are calling this Phase of recovery "Rehabilitation" (a current code word for non-medical) in a blatant attempt to exclude patients in this, the most critical Phase of recovery, from access to physicians, nurses or hospitals. It is the time in the recovery process when all therapeutic forces available must be brought to bear in maximum strength and near perfect coordination if success is to be achieved. To exclude health professionals from this phase of active treatment of the primary disease is absurd.

This is a good point at which to illustrate a serious difficulty confronting he who would attempt to diagnose and prescribe the most appropriate treatment for this disease. Not only must the diagnostician determine the Stage and the Phase of the disease, and all other interacting conditions, he must also be certain that he correlates the treatment to be given immediately and in subsequent Phases of recovery with prior treatment the patient may have received during other attempts at recovery, and during any prior Phases of the present attempt at recovery.

For example, acceptance of the anti-medical tenents of Alcoholics Anonymous definitely impairs the ability of a patient to profit from medical and/or other professional treatment, even though AA may have failed repeatedly for him. This impairment of the patient's ability to profit from medical/professional care can carry over even into Phase III of recovery which is Aftercare. It has been shown that attendance at AA meetings after treatment at Schick actually decreases the likelihood of long-term success. Studies of Schick patients have shown that only 39% of those who attend AA after completing treatment at Schick Shadel Hospital were abstinent 18 months later. In contrast, those who attend no AA afterward have a 54% 18-month abstinence rate. (See Table E of the Alcoholism Treatment Research Study, Tuchfeld and Lipton, 1982.)

Schick Shadel Hospital has developed a highly integrated multimodality treatment program which therefore cannot include AA in its treatment regimen. AA is, however, an optional addition to Schick's usually prescribed Aftercare treatment program.

The time required for resolution of Phase II varies, not with the stage of the disease at all, but with the intensity (and effectiveness?) of the treatment techniques used. Those physicians who make use of all the modern medical techniques which have been proven effective and safe, require about ten days to complete this Phase of recovery (Phase II). In contrast, those programs which utilize only professional counseling plus in-house AA in a residential setting (whether housed in the same building with a hospital, a psychiatric hospital or in its own building) require about 28 to 30 days. Alcoholics Anonymous claims that it requires at least two years to complete this phase of recovery.

Phase III: Aftercare.

Those who complete the minimal prescribed Schick Aftercare Program of two reinforcement treatments (recaps)(for a total of four days) have a 60% "18 month abstinence rate". For those who do not complete the two reinforcement visits the abstinence rate drops to 39%. Thus, there is no question of both the effectiveness and cost effectiveness of covering this four days of Aftercare for this kind of multi-modality medically supervised treatment regimen. This emphasizes again the importance of doing all that is possible to insure that appropriate Aftercare be not only encouraged but required.

This calls into stark focus Medicare Guideline 35-23 which states in part: "Followup treatments for chemical aversion therapy can generally be provided on an outpatient basis." If interpreted rigorously this would exclude virtually all Medicare patients from Schick Shadel Hospital's inpatient 4 day recap or reinforcement treatment which has been shown most conclusively to be highly effective (increasing 18 month abstinence rates from less than 40% to nearly 60%).

II. ADDICTED TO ALCOHOL

B. Complicated. Beyond the diagnosis of the uncomplicated alcohol addict, we must consider the following matters for the addict whose condition is complicated by other physical and/or psychiatric problems.

1. Psychiatric Concomitant or Complicating Conditions.

a. Psychosis

b. Depression

i. Unipolar
ii. Bipolar

c. Personality Deficits

i. Sociopathy
ii. Psychopathy

2. Medical Accompanying or Complicating Conditions.

a. Heart (myocarditis)

b. Liver

i. Fatty infiltration
ii. Alcoholic hepatitis
iii. Cirrhosis
iv. Ascites

c. Pancreatitis

d. Many others

Treatment Modalities

Now it is necessary to enumerate in broad outline those levels and kinds of treatment regimens which either have been shown, or have been thought, to be safe and effective in treating at least some Stage or Phase of some kind of alcoholism. These are:

I. Outpatient Group

  A. Medical
    1. Psychiatrist led
    2. Clinical psychologist led

  B. Non-Medical
    1. Master level counselor (MSW, M. Psychology)
    2. B. S. Level counselor
    3. "Non-degreed" alcoholism counselor (or others)
    4. Non professional, "Self-help', AA

II. Outpatient (one on one)

  A. Medical
    1. Internist counselor
    2. Internist Antabuse
    3. Psychiatric session
    4. Clinical psychologist

  B. Non-Medical
    1. Master level counselor (MSW, M. Psychology)
    2. B. S. Level counselor
    3. Non-degreed alcoholism counselor (or other)
    4. Non professional, "Self-help", AA

III. Half-Way House Level (Also nursing home, extended care)

  A. Medical - None

  B. Non-Medical
    1. Secured
    2. Not secured

IV. Residential Free Standing Non-Hospital

  A. Medical - None

B. Non-Medical
  1. Partly in-house AA
  2. Entirely in-house AA

V. Hospital Psychiatric

A. Internist Medical (as a medical detox unit)
B. Psychiatric (Alcoholics in psychiatric wards)
C. Non-Medical, Non-Psychiatric talk therapy unit merely housed in a psychiatric hospital, with no contact between psychotics and alcoholics

VI. Hospital Acute Med/Surg.

A. Medical detox unit (or intensive care)
B. Non-Medical, non-psychiatric, talk therapy and AA unit merely housed within Med/Surg Hospital

VII. Specialty Hospital

A. Medical treatment of the primary disease, alcohol addiction
B. Non-Medical
  1. Same non-medical, non-psychiatric, talk and AA unit as above but housed in a Special Hospital.

Determining the appropriateness of the level of treatment then is actually the task of matching each of the several hundred diagnostic categories (this number includes the common medical complications and concomitant diseases) with the 26 levels and kinds of treatment just given. The total number of permutations is great. I will comment only upon some of the more frequent and important.

Appropriate Kinds & Levels of Treatment

By diagnostic Category

I. Not Addicted to Alcohol

A. No Alcohol Problem

  1. Professional patient
  2. Non-alcoholic skid rower

No medical treatment is appropriate for this category.

B. Alcohol Abuse

1. Simple alcohol abuse
2. Emotional alcohol abuse
3. Poly Drug use

No medical treatment is appropriate for this category.

Alcohol abuse, defined thusly, is not a physical disease. These people can drink or not, or drink responsibly or not, to the same extent that others can. There is no justification for prescribing medical treatment, inpatient or outpatient, for this group. If no serious personality deficiencies are present, they will respond to non-medical counseling, education, threats of divorce or job loss at least as well as they will to any known medical treatment.

II. ADDICTED TO ALCOHOL

A. Uncomplicated

Determining the appropriate treatment for uncomplicated cases of physical addiction to alcohol is actually the task of matching the appropriate kind and level of treatment as enumerated above with each of the Stages and Phases of the disease discussed above. Tables I and II have been prepared to match each type of uncomplicated case with the appropriate treatment.

TABLE I

	PHASE I DETOX	PHASE II TREATMENT	PHASE III AFTERCARE
Stage 1 (early)	None	IIB	IA
Stage 1 (late)	IIA1, IIIB, IV, VA, VIA, VIIA	IIB, IIIB2, IV, VA, VIA, VIIA	I, II, VIIA
Stage 2 (early)	IV, VA, VIA, VIIA	IV, VA, VIA, VIIA	I, II, VIIA
Stage 2 (late)	IV, VA, VIA, VIIA	IV, VA, VIA, VIIA	I, II, VIIA
Stage 3 (early)	IV, VA, VIA, VIIA	IV, VA, VIA, VIIA	I, II, III, VIIA, VIIB
Stage 3 (late)	VIA, VIIA	VIIA	IIIB1, VB

ALCOHOL ABUSE

TABLE II ALCOHOL ADDICTION

Repeatedly in trouble from alcohol, life complicated by it, but individual is not physically addicted (repeated DWIs, drunk and disorderly)

Alcohol Abusers	0	Outpatient (learn skills, assertiveness training, education about alcohol) criminal sanctions, threats by wife, boss, law, etc.	Not AA Support, individual outpatient,and/or family

ALCOHOL ADDICTION

I. Increasing Tolerance
II. Plateau
III. Decreasing tolerance or the Stage of Deterioration

Treatment of this disease naturally divides itself into three sequential components each of which is indispensable in most cases.

	Phase 0 Actively Drinking	Phase I Detoxification Time Required for Withdrawal	Phase II Treatment of the Primary Disease	Phase III Aftercare Maintenance of Benefits Derived from Phase I and Phase II
Early Stage I		0	Outpatient	a) Outpatient if primary treatment was a talk program or
Late Stage 1	Intervention All Stages 1. Outpatient or 2. Legal Commitment		Residential or Specialty Hospital	b) Return to hospital for "recaps" if aversion used plus outpatient. Antabuse optional in late Stage I.
Early Stage (Plateau) Late		Social or hospital acceptable Hospital	Residential or Specialty Hospital	Same as for Late Stage 1 Same as for Late Stage 1
Early Stage 3		Hospital	Specialty Hospital	As Above for Early Stage 3
Late Stage 3		Hospital	0	Nothing but Secured Custodial Care

II. ADDICTED TO ALCOHOL

B. Complicated

1. Psychotic complications

Alcohol addicts have no more psychological or psychiatric problems, once they recover from the effects of their addiction, than does the general population; but neither do they have any less. Promulgating criteria for the "most appropriate setting" for treating those physically addicted to ethanol who also suffer from a psychiatric condition is difficult.

When the problem is more psychological than psychiatric, in my opinion, the addiction should be treated and covered by third party payors as if no other problem were present. Immediately after the initial treatment of the addiction, appropriate treatment of the psychological problem should be vigorously pursued. However, if the condition itself requires hospitalization, or if hospitalization is required for sobriety while psychological treatment is in progress, it must be ordered and should be covered both on its own merits and also because it is essential to the successful treatment of the alcohol addiction.

a. Psychosis

When the accompanying problem is clearly psychiatric, serious complications arise from the fact that many psychiatrists refuse to accept the reality of the physical nature of alcohol addiction. There are psychiatric hospitals which contain, under their roofs, but in completely separated wards non-psychiatric, non-medical alcoholism units. If such a unit is nearby and if the referring physician personally knows a psychiatrist on its staff who is capable of dealing realistically with physical addiction, then that is an ideal referral for simultaneous treatment of both conditions. If either that type unit or that type of psychiatrist is not available the referring addictologist must treat this combination exactly as he does those with simple psychological problems plus alcohol addiction. This combination is a serious problem for everyone in the field.

The psychotic alcoholic does not mesh well with any interaction group. Their psychosis insures that many in any group will respond negatively to them, which in turn aggravates their negativism. In addition most such patients cannot be helped by AA. In fact, a tenant of AA-based programs is that abstinence from alcohol is only possible if one is "chemically free", or drug free. This precludes such programs from admitting the typical schizophrenic who must chose between taking mind altering drugs daily or returning to a mental institution. Obviously they are beyond the competence of most counselors and require hospitalization. Since most hospital based units (including units housed in psychiatric hospitals) are based upon AA this leaves only the non-AA alcoholism specialty hospitals with much chance of treating their addiction.

Almost daily the physician who specializes in the diagnosis and treatment of physical addiction is called upon to arrive at a sound diagnosis and then to prescribe a treatment regimen which offers some hope of success for these cases. Obviously a non-physician could never accurately render such diagnoses and prescribe treatments appropriate for diseases of such complexity. This is, however, included in current NIAAA and HCFA proposals to allow diagnosis by persons with only high school level education. (See Guidelines For Grants For Alcoholism Services in Medicare and Medicaid, U.S.H.H.S. Office of Research, Demonstrations and Statistics, H.C.F.A., Goal B, Page 6).

b. Depression

It is essential that the depression and anxiety which are direct and inevitable consequences of alcohol addiction not be used as vehicles for admitting patients suffering from the physical disease of alcohol addiction, to psychiatric or other hospitals. Alcohol addiction clearly is not a psychiatric disease. It has neither a psychiatric cause nor a psychiatric treatment. That it has a psychiatric diagnosis is an extremely expensive absurdity. Attempting to treat it psychiatrically is extremely expensive and generally ineffective.

c. Personality Deficits (Sociopathy/Psychopathy)

In a society such as today's, many sociopaths and psychopaths will seriously abuse drugs including alcohol. "Common wisdon" often attributes their anti-social behavior to their drug abuse. Only occasionally is this the case. But the important point is that any improvement in their behavior, including alcohol and other drug abuse, generally will be short-lived. Non-psychiatric treatment will fail. While psychiatric referral is all that remains, experience has shown that even that offers little real hope.

This type is another real problem for all health professionals. Through no fault of their own these patients are inherently and apparently permanently incapable of experiencing shame, guilt, or compassion. Therefore, by nature, they are the ultimate "con-artists". They make and often become, the perfect professional patient, knowing exactly what to say and not to say and exactly how far they can go without being "expelled" from the treatment. While it is considered unseemingly, if not inhumane, to call attention to this category, it is a very real and extremely important problem for Medicare. This type is a rare among Medicare's over 65 population, but is very common among the "disabled" whom Medicare covers.

2. Medical Accompanying or Complicating Conditions

Suffice it to say that alcohol can and does derange the function, and later actually destroys the substance, of every tissue in the body. Diagnosis of the many possible medical complications due to alcohol addiction, and which of those can be expected to clear up as recovery from alcohol addiction progresses taxes the skill of the most experienced physician. Prescribing the most effective treatment setting and modality for these patients requires a great deal of specialized medical training and experience.

QUESTION NO. 4:

Does your facility have limits as to the number of treatments that will be provided to an individual? Why?

RESPONSE:

Yes, our facility does have limits to the number of treatments that will be given to an individual. Those limits are determined on an individual basis in the course of the deliberations of a committee made up of representatives from each of the clinical departments of the hospital. This committee is known as our relapse committee.

In determining whether or not to provide further treatment to an individual, the relapse committee considers many of the criteria outlined in response to Question No. 3. A general rule of thumb, however, is "three strikes and you're out". Of course, certain individuals may be refused retreatment after only one treatment program has been completed because of the nature of their relapse. On the other hand, in some cases a patient may be allowed additional treatment if the circumstances are such that it seems that he or she will benefit from that treatment. These latter cases are relatively unusual.

QUESTION NO. 5:

Your statement indicated that not all people with alcohol problems need your particular type of treatment and that not all effective treatment methods require a full hospital setting. Approximately what percentage of the people who come to Schick Shadel are considered to be appropriate candidates for your method of treatment? How are these determinations made?

RESPONSE:

We would refer the Senator to our response to Question No. 3 for a complete discussion of the many factors considered in determining whether or not a person is an appropriate candidate for treatment at Schick Shadel Hospital.

Screening for appropriateness for admission to Schick occurs at many different levels. By far most of those whose condition is not serious enough to justify our treatment are screened out either by referring professionals or agencies or at the first telephone contact with us. Others whose medical conditions make them inappropriate for our treatment are transferred or referred elsewhere either at or soon after admission by the responsible physician. These include most of those with advanced organic brain destruction. However, an adequate psychological and medical examination often cannot be done until detoxification has been nearly completed and still more are referred to more appropriate treatment at that time.

During, or after completion of, primary treatment it becomes clear that some of the borderline cases admitted to treatment simply cannot benefit from our treatment and they are so informed. And finally, as described above, the relapse committee screens relapses for readmission.

Our best estimate is that of those who contact us regarding admission and who are eligible financially we admit approximately 15%.

We are just now getting the quality of independently verified and documented outcome results upon which medical decisions can be made with confidence. Such outcome data are not available for other types of treatments available in the area. This greatly restricts everyone's ability to make rational referrals.

In addition, being the only fully medical treatment facility in the area and because of our years of experience, we accept some patients who are more seriously ill than we would like simply because there is no other treatment facility appropriate for them. In a real sense we are their court of last resort.

We are comfortable in our belief that we accept the physically addicted who can best be helped by in-hospital treatment. We are concerned about the professional patient who is adept at withholding his history and misrepresenting his condition, and those with serious personality deficiencies or advanced brain damage. We are working with clinical psychologists to perfect testing criteria to screen out these conditions earlier and more efficiently.

SPECIAL CONSIDERATIONS

The issues that you have raised by your questions move us to briefly address some additional concerns relative to these issues.

1. In light of the complexity of this disease and the victim's tendency to relapse, we feel that it is unconscionable and uneconomical to set lifetime limits on treatment. Rather, it would be more realistic to restrict coverage to a certain number of days per year so as to control against continuous but unsuccessful treatment.

2. Even after detoxification, most physicians, including Dr. Mayer, agree that if physical alcohol addiction is present, 24 hour care is mandatory. Currently, there are two basic in-house models; hospital (either psychiatric, acute medical surgical or specialty) or residential. It is important to remember that some of the non-medical (talk therapy) treatment programs are being housed in hospital settings. This, of course, is costly because of the length of most such non-medical treatment programs (approximately 30 days).

The in-house treatment options are as follows:

a. Non-medical (talk therapy) models housed in free-standing residential settings.

b. Non-medical (talk therapy) models housed in acute medical-surgical hospital settings.

(i) this model has one possible advantage to the patient of continuity from medical detox to treatment;

(ii) but that advantage is probably outweighed by the high cost of such treatment settings.

c. Non-medical (talk therapy) models housed in psychiatric hospitals (with no contact between psychotics and alcoholics).

(i) this may be advantageous for those patients requiring easy access to a psychiatrist;

(ii) but here again the advantage to most alcoholics is minimal compared to the high costs incurred.

d. Specialty hospitals using a multi-modality treatment including medical treatment in addition to talk therapy.

(i) these programs require a hospital setting for continuous medical supervision.

(ii) the cost of such treatment program settings is largely offset by the lesser time (approximately 10-14 days) required for this more intensive program.

3. Finally, we suggest that care be exercised before embracing the concept of Medicare coverage for outpatient, non-medical "treatment" programs. The idea is, of course, attractive on the surface because of an apparent cost savings. Yet, the result may well be more expensive in practice.

To emphasize cost savings over accurate diagnosis and treatment effectiveness will lead to laxity in diagnosis and duplicity in treatment. Rather than attempting to properly diagnose and prescribe appropriate treatment, it will be very easy to place all patients first in an outpatient non-medical program, reserving inpatient and/or medical treatment as a second alternative. Not only will it be easy, but it will also be very profitable for those providing both treatment settings. In fact, some institutions are now instituting duplicate programs in contemplation of such a system.

Outpatient care is not now covered in areas of proven effectiveness such as in the treatment of essential hypertension, diabetes and obesity. To extend coverage of the non-medical outpatient treatment of the disease of alcoholism before such treatment has been proven to be effective, will open the door for coverage of unproven non-medical treatment programs too numerous to list.

Conclusion

In closing, Senator Durenberger, I think you and the other members of the Subcommittee realize that our staff are professionals, sincerely dedicated to diagnosing and treating the disease of alcoholism. If our answers are verbose or overly detailed, it is because there are no easy answers. The Office of Technological Assistance has authored a report, at your request, which, we believe points this out dramatically. You cannot compare the cost effectiveness of inpatient as compared to outpatient treatment until reliable statistics are available from the outpatient people. We know that our treatment is effective almost sixty percent of the time. If the entire alcoholic population of the United States could be exposed to the treatment, the dollar savings to Medicare from the elimination of alcohol and alcohol related diseases would be astronomical. With no overstatement intended, there would probably never be a need again to cut a cent from Medicare coverage.

Again, please feel free to bring any more questions you might have to our attention.

Respectfully,

Eck G. Prud'homme, Jr., M.D.
Chief of Medical Staff
Schick Shadel Hospital of
D/FW, Inc.

ANSWERS BY HAROLD SWIFT TO QUESTIONS FROM SENATOR DURENBERGER

Question. Do you believe requiring a person to assure a greater portion of the cost of treatment—beyond the initial treatment—would enhance the probability of treatment being successful?

Answer. If I understand the question correctly, it suggests that on the second or third course of treatment, the patient would have to pay a greater portion of the cost of care. That approach would appear to be, on the surface, logical. However, I would suggest that payment be regarded as a cost-containment mechanism, rather than a tool to motivate the alcoholic. It has been my professional experience that the patient's financial investment in the course of treatment is not a significant factor in a successful clinical process. You need to be careful not to be misled by data. We can provide data indicating that our private patient, as a group, tend to produce a higher level of successful treatments. Thus, one could conclude that the person who pays their own way is more likely to maintain sobriety and, therefore, we should make other people pay and that would produce better outcomes.

However, the variable is not necessarily the money. The type of person with the financial ability to pay for all or a major portion of their cost of care needs to be examined. That person would typically be somewhat more stable, socially, vocationally, more likely to have an intact family and, in general, would be physically and emotionally in a better position to deal with the disease of alcoholism. Thus, it is not only their financial ability to pay, it is also their overall personal make-up at that time in their lives that is important. You will find lower outcomes of treatment for indigent alcoholics, than you do for the private pay patients. Again, you could conclude that is because they have no financial investment in the outcome. However, obviously, the indigent person, who has many other problems in their personal lives, would tend to have less stable social situations, less stable family situations and, obviously, less stable vocational situations. Thus, aside from their financial condition, there are many negative variables affecting treatment outcomes. If you would progressively increase the level of co-pay for subsequent courses of treatment, you would also create barriers for re-admission to treatment for people who need and want the care, but don't have the financial ability. In short, based on my over 20 years of experience in the field, perhaps contrary to advice you have heard from others.

In short, I would suggest financial participation in the cost of care is, in itself, is not the major factor in successful outcome. The issue of co-payment should be regarded as a cost-containment effort and not be rationalized as something that will produce better outcomes across the board.

Question. What has been your experience in the success of people receiving multiple treatments?

Answer. As a category, the repeat patient does less well across the board, than do first admissions. I have enclosed, for the record, a report by Dr. Laundergan that will provide you with some data on the relationship between previous treatment and client outcomes. Again, however, I would caution against pre-mature conclusions. You will note that while the success rate is lower among repeat patients, there still is a fairly positive response to treatment by individuals in that category. The variables that probably affect treatment outcome are the issues of social and economic stability, not the fact, by itself, the client had had previous treatment.

Question. How do we decide what the level of care is?

Answer. There are criteria in use in many facilities. Decisions are routinely made for outpatient vs. residential. This particular area has become increasingly important and has improved a great deal in the alcoholism field in recent years. However, a good deal more work needs to be done in developing workable and meaningful criteria. There are various formal and informal committees in Minnesota working on the issue of meaningful criteria. Ideally, the field would develop a uniform set of criteria to be used across the board, even nationally. However, the ideal is often impractical. There are many problems with criteria, one of which is tailoring the criteria to the type of patient population to be served. You will find different facilities serving different types of clientele. They differ in their socio-economic backgrounds, chronicity, stability, etc. Thus, you cannot envision one set of criteria to be used by the whole field, unless it were tailored to specific patient populations. That, in turn, is quite difficult.

Another problem with criteria is the one subject of interpretation of criteria. We see peer reviewers in the utilization review process interpreting criteria quite differently than did the clinician who provided the care. There are many intangible and subjective areas, i.e., self-worth, how does one measure self-worth, how does one measure improvement in self-worth. And, finally, criteria for admission, not only to the type of patient to be served, but to the type of service provided by a vendor. In short, this is an area in need of a good deal of refinement that may never become as concrete and measurable as we would all desire.

Question. Does your facility limit as to the number of treatments provided to an individual?

Answer. This facility has no fixed limit on the number of treatment. This is an individualized decision, that would consider progress between treatments and other variables in the patient's life. Clearly, if the patient is admitted for the third time to the same program, the appropriateness of admission to that particular facility should be considered. But we would not fix a rigid limit of three or four courses of treatment. We are familiar with many examples of individuals who have been in treatment more than three times, who were, in the end, quite successful in maintaining long-term sobriety. Or you will see patients with multiple admissions who have made reasonable progress between admissions, sufficient to justify further treatment. In our particular facility, if a patient had been admitted three or more times, with minimal progress, exhibited minimal motivation on the part of the patient, we would be inclined to refuse admission and refer the patient elsewhere.

Thank you very much for coming in a week late and for all the effort that went into your presentations.

Senator **Durenberger**. The final panel consists of Dr. Gary Graham, medical director of the Kemper Group, Long Grove, Ill.; Mr. Charles Sapp, director, employee assistance program for Connecticut General Life Insurance Co. of Hartford, Conn.

Gentlemen, we will proceed on the basis of the introduction, unless you have some preference of putting Connecticut General ahead of Kemper Group. We must have gone alphabetically.

Dr. Graham would be first.

STATEMENT OF GARY GRAHAM, M.D., CORPORATE MEDICAL DIRECTOR, KEMPER GROUP, LONG GROVE, ILL.

Dr. **Graham**. Thank you, Mr. Chairman. Good afternoon.

My name is Gary Graham, and I'm the medical director of Kemper Group. I'm very pleased to be here this afternoon to testify on alcohol treatment coverage under medicare.

In my background, besides my work with Kemper, I have had experience in Navy alcoholism treatment programs, consulting and private treatment programs, as well as some service with national insurance industry advisory boards and some State advisory boards on alcoholism.

In my prepared statement I tried to give a background of my understanding of alcoholism treatment in this country and how we have come to where we are today. Without reading that, I would point out I trace it in large part from 1935 to the founding of the fellowship of Alcoholics Anonymous. Since that time there has been steady growth with spurts and real rises at times, prompted by various influences.

The founding of AA, with its collective recovery, helped advocacy groups form. I believe that advocacy groups such as the National Council on Alcoholism were probably founded by people in recovery, their friends and families. They and other people in recovery helped companies to found programs. I think the initial company programs and employee assistance programs were probably founded by people in recovery. They led the medical community to recognize alcoholism as an illness. Not until 1951 did the World Health Organization note alcoholism was an illness; not until 1956 did the American Medical Association recognize this fact.

As we talk about insurance today, and medicare certainly is a form of a form of insurance, a public form of insurance, I can comment briefly about the private sector, being one of them there people.

The insurance industry, the private insurance industry, could not pay third party funds for an illness which had not been recognized as an illness, and there was not much health insurance in the 1940's and early 1950's.

In 1960 the first private insurance did recognize alcoholism as an illness. Kemper and Wausau are the two that are cited in 1964 as providing coverage for treatment of alcoholism. This was in those days in hospital-based programs.

I think what happened after that, and particularly because of Federal action with Public Law 91-616, is the decade of the 1970's saw real growth in alcoholism education, recognition, research, treatment, development of programs.

I feel by the time this country ended the decade of the 1970's that we led the world and continue to lead the world in many areas—the development of employee assistance programs, the development of treatment centers, moneys spent on treating an illness. An Endata survey pointed out that in 1979, $795 million were spent on alcoholism treatment in over 4,000 treatment facilities with an estimated capacity of 360,000. And I tend to be very upbeat about what we have accomplished in this country in less than 50 years concerning recognizing a very fatal illness and treating it.

I think, as impressive as all that is, the facts that you have heard today already from all of the other witnesses points to the immense problem that we continue to have in this country.

You, in your opening statement today, used a figure which is strangely similar to a figure that I use in my testimony, of $18.2 billion impacted in health and medical cost care of people with alcoholism.

I have stated in my statement, at least—and Congressman Mills may be right, it may be our leading cause of death—it certainly is our third leading cause of death in this country. Strangely enough, that fact is not recognized by Health and Human Services. Alcoholism doesn't appear as a diagnosis, as a cause of death; and yet all it's complications are in some category or other: Accidents, cirrhosis is the seventh leading cause of death, and that's just one of the many complications of alcoholism.

I have always thought it interesting that from a medical perspective alcoholism most often kills people long before their body gets real sick with the illness. Most people that have hepatic failure have been lucky to have survived motor vehicle accidents, falls, drownings, and unsuccessful suicides. They survive all of the traumatic complications before their body finally gets ill.

Cost, again, I need not review; but what I would like to do is to make two statements about alcoholism today:

One is, we know that alcoholism treatment works. In the past two decades hundreds of thousands of people have been helped into the recovery process. And I think it is very interesting that, unlike other fatal and progressive illnesses such as coronary artery disease—I am a cardiologist, and I should be able to say that. In coronary artery disease we have not had good cost benefit studies on whether you should admit people for hospitalization when they have angina or when they have a heart attack or when they need bypass surgery or when they need restudy or when they need another bypass study. The cost benefits of coronary disease I'm sure would not look good to us at all. And yet, alcoholism has been forced to do that, and the studies have shown good things.

I cite in my statement a review by Jones and Vishney in 1979 that looked at 12 alcoholism treatment studies. All of them showed a reduction in medical care utilization or expenditures when compared to those same individuals before treatment. The reductions ranged from 26 to 69 percent, with a median reduction of 40 percent.

I'm sure my colleague will probably speak about his own program and some of the cost effect, perhaps, of their excellent program. Other studies have shown declines of 57 percent in outpatient and inpatient costs in the treated individual.

A recent California public employee study from 1981 showed a 31-percent reduction in the use of general health services following treatment, and a 57-percent reduction—and I think this is really striking—a 57-percent reduction in family utilization of the health services; again, bringing up what Congressman Mills was saying about the family nature of the illness.

An interesting and I think I called it striking—I've already used that word so we'll strike that—study was made by Rieff and some people in 1981, looking at a Los Angeles area Kaiser Foundation plan, where people were compared, treated and non-treated. What did was when people were referred to a treatment program and chose not to participate in it, they continued to follow them as well as those who did participate for a very limited outpatient program—at least four visits was the criteria for being treated. Many had more visits than that. The statistics, again, were interesting. For over 3 years in follow up, those people that were treated showed an average dollar cost decrease in utilizing inpatient and outpatient other services of $144—minus $144 per patient per year in follow up. Those people who did not avail themselves to treatment showed an increase of $457 per year per patient. So well over $500 difference.

Again, I sometimes have some anger about having to cost justify treating alcoholism, but there are studies that show it is even cost beneficial.

Second, as you've heard again today, the whole field of alcoholism treatment is changing—has changed and is changing. Mr. McElfresh pointed out the various levels of care that people can appropriately be referred to: Freestanding programs are well established now; quality outpatient programs are now well evolved.

The outpatient programs use is limited by some. We at our company have benefits for our employees. They may be referred to use outpatient treatment rather than costly inpatient treatment.

There are some more figures, again, on the difference in cost, which should be obvious.

I also, in my prepared statement, will note some of the things that have influenced insurance coverage, those States that have mandated legislation and required that alcoholism coverage be made available.

Let me say in closing that we favor the utilization of various forms of treatment—freestanding, hospitalization, and outpatient treatment. We think that not only will they be cost-effective but in fact total health care cost in the population, particularly affected by alcoholism and therefore their contribution to the population covered, will be influenced.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. Gary Graham follows:]

STATEMENT
GARY GRAHAM, M. D.
CORPORATE MEDICAL DIRECTOR
KEMPER GROUP
JULY 27, 1982 - SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON ALCOHOL TREATMENT COVERAGE UNDER MEDICARE

MY NAME IS DR. GARY GRAHAM. I AM THE CORPORATE MEDICAL DIRECTOR FOR THE KEMPER GROUP, AND WELCOME THE OPPORTUNITY TO APPEAR BEFORE THE SEANTE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON ALCOHOL TREATEMENT COVERAGE UNDER MEDICARE.

IN ADDITION TO MY WORK FOR KEMPER, MY BACKGROUND INCLUDES EXPERIENCE AS A DIRECTOR OF A NAVY ALCOHOLISM TREATMENT PROGRAM, CONSULTATION TO PRIVATE ALCOHOLISM TREATMENT PROGRAMS AND SERVICE ON INSURANCE INDUSTRY ADVISORY BOARDS ON ALCOHOLISM COVERAGE AND STATE ADVISORY BOARDS ON ALCOHOLISM.

TODAY, I WOULD LIKE TO PRESENT A BRIEF BACKGROUND ON THE DEVELOPMENT AND CURRENT STATUS OF ALCOHOLISM TREATMENT, THE COST-BENEFITS ACCURED IN TREATING ALCOHOLISM, THE CHANGES THAT ARE OCCURRING IN TREATMENT AND RATIONALES FOR CHANGING COVERAGE FOR ALCOHOLISM TREATMENT TO THE MEDICARE RECIPIENT.

PRIOR TO 1935, THOSE INDIVIDUALS WITH THE ILLNESS OF ALCOHOLISM WERE RARELY ABLE TO RECOVER. SOME WERE HELPED BY THE FEW TREATMENT PROVIDERS AVAILABLE WHILE OTHERS ACHIEVED ISOLATED RECOVERY AIDED BY FAMILY, FRIENDS OR CHURCH. IN 1935, THE FOUNDING OF THE FELLOWSHIP OF ALCOHOLICS ANONYMOUS (AA) WITH ITS CONCEPTS OF COLLECTIVE RECOVERY AND REACHING OUT TO HELP OTHERS BEGAN AN UNPARALLED ADVANCE IN THE TREATMENT OF A FATAL DISEASE.

RECOVERING ALCOHOLICS, THEIR FAMILIES, FRIENDS AND ENGLIGHTENED COMMUNITY LEADERS JOINED FORCES TO FORM LOCAL COUNCILS AND, IN 1944, FORMED THE NATIONAL COUNCIL ON ALCOHOLISM (NCA). AS A PARALLEL TO ADVOCACY GROUP DEVELOPMENT, A FEW COMPANIES, AT THE URGING OF RECOVERING ALCOHOLIC EMPLOYEES, BEGAN EMPLOYEE ASSISTANCE PROGRAMS (DUPONT IN 1943 AND EASTMAN-KODAK IN 1944).

BY THE 1950'S, THE MEDICAL COMMUNITY HAD BEEN LED TO AN INITIAL UNDERSTANDING OF ALCOHOLISM AS AN ILLNESS WITH FORMAL RECOGNITION OF THIS FACT BY THE WORLD HEALTH ORGANIZATION IN 1951 AND THE AMERICAN MEDICAL ASSOCIATION 1956.

DURING THE NEXT DECADE, THE GROWING PRIVATE HEALTH

INSURANCE INDUSTRY BECAME AWARE OF THE NEED TO PAY FOR TREATMENT OF THE PRIMARY ILLNESS - ALCOHOLISM - RATHER THAN TO PAY ONLY FOR THE TREATMENT OF ITS COMPLICATIONS. THIS WAS LED BY CARRIERS SUCH AS KEMPER AND WAUSAU IN 1964.

IN 1970, PASSAGE OF THE COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT AND REHABILITATION ACT (P.L. 91-616) COMMITTED THE FEDERAL GOVERNMENT TO AID IN THE DEVELOPMENT OF TREATMENT AND OCCUPATIONAL PROGRAMS. THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA), SINCE ITS CREATION IN 1971 BY THIS ACT, HAS BEEN A FORCE IN THE EFFORT TO EXPAND KNOWLEDGE OF THE ILLNESS, IMPROVE RECOGNITION AND ENCOURAGE TREATMENT.

IN THE 1970'S, THIS NATION LED THE WORLD IN APPROACHING THE ILLNESS ON MANY FRONTS: RESEARCH AND EDUCATION, STARTING ALCOHOLISM TREATMENT PROGRAMS, DEVELOPING EMPLOYEE ASSISTANCE PROGRAMS, DECRIMINALIZING CHRONIC PUBLIC INTOXICATION, AND INCREASING HEALTH INSURANCE COVERAGE. THUS, BY 1980, THERE WERE OVER 4000 TREATMENT FACILITIES AVAILABLE WITH A CAPACITY OF 360,000. IN 1979, $795 MILLION DOLLORS WERE SPENT BY FEDERAL, STATE AND PRIVATE SOURCES FOR ALCOHOLISM TREATMENT. OVER 4000 COMPANIES HAD SOME FORM OF EMPLOYEE ASSISTANCE PROGRAMS AND INCREASING NUMBERS OF AMERICANS

HAD SOME FORM OF HEALTH INSURANCE COVERAGE FOR ALCOLHOLISM TREATMENT.

AS IMPRESSIVE AS THIS GROWING AWARENESS AND RESOURCE DEVELOPMENT IS, IMMENSE CONSEQUENCES FROM UNTREATED ALCOHOLISM CONTINUE. ALCOHOLISM IS THE THIRD LEADING CAUSE OF DEATH IN THE UNITED STATES TODAY. EVEN THOUGH THIS DISEASE DOES NOT APPEAR IN HEALTH AND HUMAN SERVICE DEPARTMENT LISTINGS, ONE OF ITS MEDICAL COMPLICATIONS, CIRRHOSIS OF THE LIVER, IS BY ITSELF THE SEVENTH LEADING CAUSE OF DEATH. UNFORTUNATELY, MANY PEOPLE WITH ALCOHOLISM DIE OF TRAUMA - MOTOR VEHICLE ACCIDENTS, FALLS, FIRES, DROWNINGS, SUICIDES AND HOMICIDES - BEFORE THE POTENTIALLY FATAL MEDICAL COMPLICATIONS OF CIRRHOSIS, GASTROINTESTINAL BLEEDING, PANCREATITIS OR CARDIOMYOPATHY OCCUR.

OUR HOSPITALS ARE FILLED WITH PEOPLE WITH THE COMPLICATIONS OF THIS ILLNESS - BOTH TRAUMATIC AND MEDICAL. EXCLUDING OBSTETRICAL CASES, ESTIMATES OF ALCOHOL RELATED HOSPITALIZATION IS FROM 30% TO 50% OF ADMISSIONS. MANY OF THOSE WITH ALCOHOL RELATED ADMISSIONS HAVE ALCOHOLISM WHICH IS THE ILLNESS WHICH REQUIRES PRIMARY TREATEMENT.

THE ECONOMIC COSTS OF ALCOHOL MISUSE AND ALCOHOLISM ARE

STAGGERING. THE DOLLAR AMOUNT ESTIMATED IN 1975 AT $43 BILLION HAS CERTAINLY GROWN TO OVER $60 BILLION TODAY.

WITH THESE FACTS IN MIND, WHAT IS OCCURRING IN ALCOHOLISM, AND HOW MAY CHANGES IN MEDICARE COVERAGE BE COST BENEFICIAL?

FIRST: ALCOHOLISM TREATMENT WORKS.
IN THE PAST TWO DECADES, HUNDREDS OF THOUSANDS OF INDIVIDUALS HAVE BEEN HELPED INTO THE RECOVERY PROCESS. UNLIKE OTHER FATAL AND PROGRESSIVE ILLNESSES SUCH AS CORONARY ARTERY DISEASE, NUMEROUS STUDIES TO EXAMINE THE BENEFITS DERIVED FROM TREATING ALCOHOLISM HAVE BEEN CONDUCTED. THESE STUDIES HAVE UTILIZED VARIOUS OUTCOME MEASUREMENTS SUCH AS SURVIVAL, SUBSEQUENT MEDICAL CARE COSTS, ACCIDENT FREQUENCY, ABSENTEEISM AND WORK PERFORMANCE.

IN EXAMINING SOME OF THESE STUDIES, JONES AND VISCHI IN A REVIEW IN 1979, NOTED THAT IN TWELVE ALCOHOLISM TREATMENT STUDIES, ALL FOUND A REDUCTION IN MEDICAL CARE UTILIZATION OR EXPENDITURES WHEN COMPARED TO THOSE BEFORE TREATMENT. THESE REDUCTIONS RANGED FROM 26% TO 69% WITH A MEDIAN REDUCTION OF 40%. ONE OF THESE STUDIES SHOWED 69% FEWER HOSPITAL DAYS UTILIZED. A STUDY BY BLUE CROSS OF WESTERN PENNSYLVANIA SHOWED A 57% DECLINE IN INPATIENT AND OUTPATIENT EXPENDITURES FOLLOWING TREATMENT. A KENNICOTT STUDY

DEMONSTRATING A 40% DECLINE IN HOSPITAL MEDICAL AND SURGICAL COSTS. A RECENT CALIFORNIA PUBLIC EMPLOYEES' STUDY SHOWED A 31% REDUCTION IN THE USE OF GENERAL HEALTH SERVICES FOLLOWING TREATMENT, AND A 57% REDUCTION IN FAMILY UTILIZATION OF HEALTH SERVICES (AGAIN DEMONSTRATING FAMILY INVOLVEMENT IN THE ILLNESS).

A STRIKING STUDY WITH A THREE YEAR FOLLOW-UP WAS REPORTED BY RIEFF ET. AL. IN 1981. THIS WAS A COMPARISON STUDY CONDUCTED IN A LOS ANGELES AREA KAISER FOUNDATION PLAN. INDIVIDUALS REFERRED FOR OUTPATIENT ALCOHOLISM TREATMENT WERE FOLLOWED IN COMPARISON GROUPS - THOSE WHO PARTICIPATED IN TREATMENT (FOUR OR MORE VISITS) AND THOSE WHO DID NOT. THE DOLLAR COST IN UTILIZING INPATIENT AND OUTPATIENT SERVICES DECREASED IN THE TREATED GROUP BY $144 PER YEAR (-$144) WHILE IT INCREASED BY $457 (+$457) IN THE GROUP NOT PARTICIPATING IN TREATMENT - AN OVER $500 DIFFERENCE PER PATIENT PER YEAR.

SECOND: ALCOHOLISM TREATMENT IS CHANGING.
AS TREATMENT PROGRAMS BEGAN, INITIALLY TREATING THOSE PERSONS IN AN ADVANCED STATE OF THE ILLNESS, MOST WERE HOSPITAL BASED. IT BECAME APPARENT THAT THE TREATMENT OF ALCOHOLISM DID NOT REQUIRE THIS HIGH COST MEDICAL CARE,

PARTICULARLY IN PEOPLE IN THE EARLY AND MIDDLE STAGES OF THE ILLNESS. THIS, COUPLED WITH A MULTI-DISCIPLINARY APPROACH TO TREATMENT INVOLVING TRAINED ALCOHOLISM COUNSELORS, PSYCHOLOGISTS, PASTORS AS WELL AS PHYSICIANS LED TO THE FORMATION OF FREE-STANDING (NON-HOSPITAL BASED) RESIDENTIAL ALCOHOLISM TREATMENT FACILITIES. THERE WERE 2,290 OF THESE BY 1980 (NDATUS). MOST OF THE SUPPORT OF THESE FACILITIES COMES FROM FEDERAL, STATE AND LOCAL GRANTS OR PATIENT FEES. SOME, 306 (13.4%) ARE REIMBURSED BY PRIVATE INSURANCE CARRIERS, BUT NONE CAN BE REIMBURSED UNDER MEDICARE.

A MORE RECENT INNOVATION HAS BEEN THE DEVELOPMENT OF EFFECTIVE INTENSIVE OUTPATIENT ALCOHOLISM TREATMENT PROGRAMS - EITHER HOSPITAL BASED OR FREE STANDING. WITH A SELECTED POPULATION, THESE PROGRAMS WHICH MAY INCLUDE 40-60 HOURS OF THERAPY OVER A 3-6 WEEK PERIOD OF TREATMENT HAVE BEEN SUCCESSFUL. FOR COMPANIES UTILIZING EVENING OUTPATIENT PROGRAMS, THEIR EMPLOYEES CAN CONTINUE THEIR WORK AND LIVE AT HOME, AVOIDING "RE-ENTRY" PROBLEMS WHICH MAY OCCUR FOLLOWING RESIDENTIAL TREATMENT. OUR COMPANIES' EMPLOYEE ASSISTANCE PROGRAM RECOGNIZED THIS BENEFIT, AND IN 1973, WE CHANGED OUR EMPLOYEES' BENEFITS TO INCLUDE THIS. OVER THE PAST FEW YEARS, WE HAVE HAD NUMEROUS EMPLOYEES ENTER RECOVERY THROUGH OUTPATIENT TREATMENT, AND HAVE HAD FEWER

EMPLOYEES IN RESIDENTIAL TREATMENT PROGRAMS. OUTPATIENT TREATMENT ALLOWS FOR THE "FALL-BACK" OPTION OR RESIDENTIAL TREATMENT SHOULD ABSTINENCE NOT BE CONTINUED OR RELAPSE TO OCCUR.

THE COST DIFFERENCE IN THESE THREE TREATMENT APPROACHES IS OBVIOUS. HOSPITAL BASED TREATMENT IS THE MOST EXPENSIVE, RESIDENTIAL FREE-STANDING TREATMENT LESS EXPENSIVE AND OUTPATIENT TREATMENT THE LEAST EXPENSIVE TREATMENT MODALITY. THE NDATUS REPORT IN 1980 STATED THE COST PER CLIENT YEAR SHOWED AVERAGE FIGURES OF $13,730, $4,730 AND $740 FOR THESE THREE TREATMENT FORMS. IN A REPORT BY AETNA LIFE AND CASUALTY CO. IN MAY 1980 ON COST AND UTILIZATION UNDER THE FEDERAL GOVERNMENT WIDE INDEMNITY BENEFIT PLAN, OF 588 PERSONS TREATED, 397 (80%) WERE TREATED IN HOSPITAL BASED PROGRAMS AT AN AVERAGE DAILY COST OF $146.76. THOSE 99 (20%) TREATED IN AN APPROVED FREE-STANDING RESIDENTIAL PROGRAM HAD AN AVERAGE DAILY COST OF $116.05. FREE-STANDING TREATMENT WAS 21% LESS EXPENSIVE THAN HOSPITAL TREATMENT.

A BLUE CROSS AND BLUE SHIELD OF MICHIGAN REPORT FOR THE YEAR ENDING IN DECEMBER, 1979, STATED THAT FROM A BASE OF 1,922,897 SUBSCRIBERS, 13,021 PEOPLE WERE TREATED FOR ALCOHOLISM. THIS TREATMENT WAS GIVEN BY 72 PROVIDERS.

TWO THOUSAND TWO HUNDRED THIRTY-FIVE PERSONS RECEIVED RESIDENTIAL TREATMENT AT AN AVERAGE COST OF $2,420.58. TEN THOUSAND SEVEN HUNDRED EIGHTY-SIX PERSONS UTILIZED SOME FORM OF OUTPATIENT TREATMENT AT AN AVERAGE COST OF $100.95. THE RESIDENTIAL TREATMENT WAS NOT DIVIDED INTO HOSPITAL OR FREE-STANDING FACILITIES.

THE GROWTH OF THESE TREATMENT OPTIONS HAS BEEN STIMULATED BY INSURANCE COVERAGE PROVIDING THIRD PARTY PAYMENT IN THE PRIVATE SECTOR. THE KEMPER INSURANCE COMPANY IN JUNE 1973, PROVIDED BENEFITS FOR OUTPATIENT TREATMENT OR RESIDENTIAL TREATMENT IN STATE-LICENSED OR APPROVED ALCOHOLISM TREATMENT FACILITIES.

THE PRIVATE HEALTH INSURANCE INDUSTRY HAS BEEN INFLUENCED TO PROVIDE COVERAGE FOR ALCOHOLISM TREATMENT BY STATE STATUTES MANDATING OR REQUIRING TREATMENT OPTIONS. IN 1972, WISCONSIN ENACTED LEGISLATION FOR ALCOHOLISM TREATMENT COVERAGE. BY SEPTEMBER, 1981, THERE WERE 33 STATES WITH LAWS REGULATING ALCOHOLISM TREATMENT COVERAGE. THE LEGISLATION IN 17 OF THESE STATES INCLUDES MANDATORY COVERAGE FEATURES. IN 29 STATE STATUTES, RESIDENTIAL NON-HOSPITAL BASED TREATMENT FACILITIES ARE COVERED. OUTPATIENT SERVICES OR OUTPATIENT TREATMENT SETTINGS ARE

MENTIONED WITHIN 20 STATE STATUTES.

WITH THIS BACKGROUND ON ALCOHOLISM TREATMENT, THE COST-BENEFITS OF TREATMENT AND CHANGES IN TREATMENT PROGRAMS, LET ME ADDRESS THE POPULATION COVERED BY MEDICARE ADMINISTERED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA), TITLE XVIII OF THE SOCIAL SECURITY ACT.

MANY OLDER PERSONS WITH ALCOHOLISM ARE OVERLOOKED OR IGNORED BECAUSE THEIR BEHAVIOR IS NOT SOCIALLY DISRUPTIVE. THOSE WHO HAVE PHYSICAL PROBLEMS SECONDARY TO ALCOHOLISM, MAY HAVE THESE PROBLEMS ATTRIBUTED TO OTHER HEALTH PROBLEMS. IN RETIREMENT, THE ALCOHOLIC INDIVIDUAL WILL NOT BE REACHED BY AN EMPLOYEE ASSISTANCE PROGRAM. IT HAS BEEN ESTIMATED THAT 10% OF MEN AND 2% OF WOMEN 65 YEARS AND OLDER ARE PROBLEM DRINKERS. THIS WOULD TOTAL 1,105,000 PEOPLE IN THIS AGE GROUP. OF THESE, FEWER THAN 10% ARE RECEIVING ANY KIND OF TREATMENT.

SINCE 1965, WHEN THE MEDICARE LAW WAS PASSED, ALCOHOLISM COVERAGE HAS COME UNDER THE MENTAL ILLNESS CATEGORY. THUS, IN PART A THERE IS THE MENTAL ILLNESS 190 DAY LIFETIME BENEFIT. CERTAINLY, THIS LIMIT IS SUFFICIENT FOR RESIDENTIAL ALCOHOLISM TREATMENT WITH MOST PROGRAMS LASTING LESS THAN 35 DAYS. HOWEVER, THIS TREATMENT MUST

OCCUR IN A HOSPITAL BASED OR PSYCHIATRIC HOSPITAL BASED PROGRAM, THE MOST EXPENSIVE TREATMENT FORM.

OUTPATIENT ALCOHOLISM (MENTAL HEALTH) SERVICES REQUIRE A 50% COINSURANCE WITH A $250 MAXIMUM BENEFIT, A MAXIMUM WHICH HAS NOT CHANGED SINCE 1965. THUS, THE OLDER POPULATION COVERED, MANY WITH LIMITED RESOURCES, EVEN WHEN MOTIVATED TO TREATMENT CANNOT UTILIZE OUTPATIENT ALCOHOLISM TREATMENT PROGRAMS.

OUR AGED POPULATION CONTINUES TO BE IN A PERILOUS SITUATION. THERE SEEMS TO BE LESS ENTHUSIASM IN RECOGNIZING THE ILLNESS IN THIS GROUP, OR WHEN RECOGNIZED, INTERVENING AND GUIDING THEM TO TREATMENT. THIS TOGETHER WITH THE LEAST COST-BENEFICIAL TREATMENT CHOICE CONTINUES TO UNDERSERVE THE MEDICARE RECIPIENT. THEY, AS ALCOHOLICS OF ALL AGES, CONTINUE TO HAVE THE TRAUMATIC AND MEDICAL COMPLICATIONS OF THE ILLNESS, AND THOSE ARE PAID FOR BY THEIR MEDICARE COVERAGE.

I WOULD URGE YOU TO CONSIDER A MECHANISM TO MAKE THE MEDICARE COVERAGE FOR ALCOHOLISM MORE AVAILABLE AS WELL AS COST BENEFICIAL. BY INCLUDING APPROVED, LICENSED FREE-STANDING FACILITIES, AND OUTPATIENT BENEFITS FOR ALCOHOLISM TREATMENT, MORE PEOPLE COULD BE SERVED IN A LESS EXPENSIVE WAY RESULTING IN A SAVINGS IN TOTAL HEALTH CARE COSTS.

Senator DURENBERGER. Mr. Sapp?

STATEMENT OF CHARLES SAPP, DIRECTOR, EMPLOYEE ASSISTANCE PROGRAM, CONNECTICUT GENERAL LIFE INSURANCE CO., HARTFORD, CONN.

Mr. SAPP. Thank you very much.

I appreciate the opportunity to have been here today. In addition to my experience with the Navy's alcoholism prevention program, and for the last 4 years as director of Connecticut General's employee assistance program, I am also one of those 14 million alcoholic Americans that have suffered or are suffering from this disease.

And I would like to emphasize something I think that Mr. Mills brought up, that it is a family illness, and that every alcoholic by at least four other people adversely, to the point where those people are also in need of therapy or treatment. So we are really talking about probably another 60 million Americans that are suffering from the disease of alcoholism.

I think it is important that we recognize that, and if you are going to do anything under the medicare system that you include these people in whatever system you do develop.

Interestingly, too, only about 10 percent of the alcoholics will recover and maintain sobriety and lead productive lives again.

I don't mean to paint a doom and gloom picture, because it really isn't like that. In the past 10 years there have been tremendous strides made in the field of alcoholism: The provision for good treatment facilities, the provision a lot of corporations have in fine employee assistance programs, and all of that is helping the alcoholic.

I think all of us sort of owe a debt of gratitude to Senator Harold Hughes and to the whole Congress at that time for the implementation of the alcoholism legislation that led to helping more and more alcoholics.

From my standpoint as employee assistance director it is very, very cost effective, as Dr. Graham said. We have found at Connecticut General that the employee assistance program provides an avenue that is not only worthwhile for the alcoholic but is also worthwhile for the corporation. What is good for the alcoholic is generally good for the corporation. We can confront, identify, and refer an alcoholic, and use a hammer that is the threat of loss of job, and it seems to be very, very effective; where the alcoholic threatened with losing a family, for instance, plenty of people get divorces that aren't alcoholics, so that's not as much of a hammer.

I don't know what incentive you can have when it comes to the elderly, but I think you have to have some incentive. Maybe one of the incentives would be that it's not too costly for the elderly to get into treatment.

Now, one of the frustrations we run into in the EAP field is treatment, and that's what this hearing is all about, and the cost thereof.

At Connecticut General we have very good coverage, but we do not cover, for instance, outpatient care unless it is with a Ph. D. clinical psychologist or a psychiatrist.

To give you an example of a treatment facility, there is a beautiful facility in the hills of Connecticut where thousands of alcoholics have been treated. I know doctors, lawyers, businessmen, and women, policemen, housewives, et cetera, that are sober today because of treatment they received at this facility.

The officer at Connecticut General that is responsible for the establishment of the EAP program there is also a graduate of that facility.

Now, inflation has hit us all, and it has hit this facility. The cost in the last 4 years has risen from $120 to $150 per week. Per week.

Now, one can say, "Well, that can't be a very comprehensive model," and no, it isn't. But the fact is that thousands of people are sober today because of treatment they received at that facility at $150 per week.

There are degrees of alcoholism as there are degrees of other illnesses. I don't mean to imply that every alcoholic could get sober at that facility. But I do mean to imply that if there are degrees of illness, then most alcoholics do not need comprehensive inpatient care.

This facility that I was talking about emphasizes the program of Alcoholics Anonymous, and in my opinion for the great majority of alcoholics that is the solution to long-term sobriety.

It also stresses the family and getting the family involved, and I think any good treatment program today must stress the involvement of the family.

Again, I don't mean to imply that everyone can get sober through that facility.

As far as insurance companies are concerned and coverage, I think we have taken sort of a bum rap because I don't feel that it's the insurance companies' fault that other treatment facilities and other treatment modalities are not covered under third party payment.

Part of it rests with the State and Federal governments in their lack of certifying or making standards available and making credentials available for alcoholism counselors. Alcoholism counselors are really the unsung professionals of this whole field. There are many, many alcoholics that could do just as well with an alcoholism counselor as with a psychiatrist. I think until the time comes till we have proper certification, then we really aren't going to see much done as far as the reduction of cost for the treatment of alcoholism.

Finally, as far as medicare is concerned, I think one first step that you could do almost immediately, it seems to me, and again maybe I oversimplify, would be to look at corporations such as Kemper, Connecticut General, and other large corporations to see what they are providing as far as alcoholism coverage for their own employees and get the best of all of them, and start making that available under medicare.

In long term, I would like to see a network of outpatient treatment facilities nationwide where the elderly can go in a less threatening area, and also where it would be less expensive for them. I think in the long run it will not only make good human sense but it will also make good business sense for the Government.

Thank you.

[The prepared statement of Charles Sapp follows:]

Senate Finance Subcommittee on Health
Hearing Tuesday, July 27, 1982

STATEMENT

(C. Sapp)

In the past ten years I have personally worked with and counseled over 1,000 alcoholics. I have found, as is frequently written, that there is no "typical" alcoholic. I am encouraged that some of the stereotyping and stigma are being erased. This is due in part to education of the general public and, in part, to the advent of Employee Assistance Programs.

I think the nature and value of most Employee Assistance Programs (EAP's) can be seen in the CG Corporate Policy on the Employee Assistance Program:

> "It is the policy of Connecticut General to provide professional consultation and referral for employees who are experiencing personal problems of such significance that satisfactory performance is or may be impaired. An employee's work performance may be affected when a family member has a personal problem. For this reason, the same offer of assistance is extended to the spouse or other members of the employee's immediate family."

The impact of this for the alcoholic can be summarized as follows:

(1) Because the program provides for consultation and referral in-house but not treatment, the nature and cost of treatment programs is of concern to us.

(2) Because the service is available to individuals no matter what type of personal problem they may feel they have ("broad-brush" coverage), we see many situations in which the individual comes in with a stated problem and it turns out the stated problem is secondary and stems from the employee or family member's drinking problem.

(3) The EAP is an ideal way of getting the alcoholic employee to treatment. The possibility of losing a job is very often the crisis in the employee's life that will get him/her to seek help, and it is much easier to have the help immediately available through the EAP.

(4) Having the assistance available to family members has enabled us to help many alcoholics of whom we would not otherwise be aware. An alcoholic spouse may be identified and helped by the employee or by the spouse himself/herself knowing of the availability of assistance through the EAP. The same is true of elderly relatives.

(5) CG also feels a responsibility to their retirees; therefore all retirees, regardless of medical coverage, are eligible for assistance through the EAP. In one case, a retiree's son was helped by the EAP and entered treatment for alcoholism. The retiree was very grateful for the help offered free of charge to her by the company. We have also assisted retirees by finding a treatment facility that is affordable under any medical benefits they may have. This same service has been provided for elderly parents of employees.

Although cost savings (or cost avoidance) of helping alcoholic employees or relatives is difficult to state with precision, we found that supervisors of alcoholic employees seeking help through the EAP tended to confirm the NCA figure of 25% of salary lost each year due to absenteeism, accidents, poor productivity, etc. Looking at the short, unplanned absences (which are particularly disruptive) for our alcoholic employees a year before and a year after seeking help through the EAP, we found a decrease of 46% in short-term absences.

Two statements need to be made before commenting on alcoholism treatment: (1) alcoholism is a primary illness; it is not a symptom of an underlying problem; and (2) there are degrees of alcoholism as there are degrees of other illnesses. Some alcoholics will recover and maintain sobriety without any formal treatment program solely through the program of Alcoholics Anonymous (AA). Others may require in-patient treatment (the most effective in-patient programs emphasize the importance of AA as a resource for long term sobriety, and education about AA is an integral part of the program).

In-patient alcoholism treatment has over the past ten years become big business. There has been a proliferation of facilities, and costs have sky-rocketed. The average cost of a comprehensive, 28 day in-patient program is $5,000-$6,000; out-patient care could cost less than $1,000. As previously stated, there are degrees of alcoholism - every alcoholic certainly does not need in-patient treatment. Connecticut General has good coverage, but the lack of licensed out-patient facilities and counselors covered by third party payers limits the options available to us when we refer employees or their dependents. At present, if I see an alcoholic in my office who I believe could be successfully treated on an out-patient basis and this alcoholic also has severe financial problems (which is frequently the case - drinking is expensive and alcoholics tend to become financially irresponsible), I will probably refer that client to an in-patient treatment facility because the total cost of the treatment will be covered by Connecticut General. If I referred the client to an out-patient treatment facility, the financial problem would be compounded and the client would probably not go for treatment at all. In my opinion, a nationwide network of licensed, out-patient alcoholism treatment centers would significantly reduce the costs of alcoholism treatment.

The question has frequently been raised as to why insurance companies pick up the cost of more expensive care and not of out-patient treatment. In particular, those not eligible for third-party payment have been critical of the insurance industry, and some of these people have been adversely impacted when we "over-refer."

It would seem logical that the insurance industry would like nothing better than to have an alternative for the very expensive treatment that they are paying for at the present time. Unfortunately, Federal and most state authorities have not established standards and licensing requirements for out-patient programs and individual therapists. In-patient programs, on the other hand, are reviewed by the JCAH, inspected, licensed, etc. Although the staff of an in-patient facility may include psychiatrists and clinical psychologists, it also includes counselors who could be involved in a third-party approved out-patient program as well as individual practice if certification and licensing were obtainable.

I have been personally involved in the past six years in the frustrating efforts to provide the necessary recognition for alcoholism counselors. Eight years ago a study funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) resulted in a report entitled "Proposed National Standards for Alcoholism Counselors." This report recommended standards to be used in a national voluntary certification program. State boards were recommended as mechanisms for review of applications and administration of a national examination. NIAAA policy decisions at that time precluded further action; however, debate continued in the field concerning steps to be taken to provide for alcoholism counselor certification. Through the efforts of various organizations the NIAAA was persuaded to establish a Planning Panel for Certification. The results of the deliberation of the Panel were publicized in February, 1977:

"The NIAAA Planning Panel recommends that a National Credentialing Organization for Alcoholism Counselors be established. The implementation of the National Credentialing Organization should be accomplished in three distinct phases to allow for the orderly evolution of the organization and its acceptance by the field of alcoholism. To assure that the goals and objectives of National Credentialing Organization are consistent with the needs of the alcoholic patient, the initial Board of Directors should be as representative of the field of alcoholism as is possible, thus allowing for the valued input of interested persons throughout the formative phases of the National Credentialing Organization's development.

The National Credentialing Organization should be as self-supporting as is possible, relying on federal support only for some of its initial start-up costs and for task-oriented projects obtained on a competitive basis."

The establishment of the National Commission on Credentialing of Alcoholism Counselors followed in 1978, but various factions still debate the issues and there are no national standards. Some states have taken action and developed standards and certification requirements. Other states have taken little action. A contract was recently awarded by the NIAAA to again develop proposed national standards. I would like to see strong support for the NIAAA's effort to develop model standards and licensing requirements for alcoholism counselors. I am not suggesting that the Federal government dictate standards or licensing requirements to the state, but I am suggesting that the Congress should give its support to the states and peer organizations. In this way the insurance industry would have criteria for coverage of individuals and organizations based on the standards established for certified counselors.

The extent of even in-patient treatment that is covered depends, as do many benefits, on state requirements and the nature of the insurance provisions that are negotiated with a company. For its own employees in the Greater Hartford area, CG provides payment for the "reasonable and customary charges for each day of confinement, up to 45 days in a calendar year." In actuality, although the inclusion of these provisions in the basic medical benefits package has been crucial to the success of Employee

Assistance Programs, the benefit is generally not used to its fullest. It is impossible to predict what treatment modality, if any, will work for an employee the first time. Some employers, after an employee has had one opportunity at treatment, will terminate the employee automatically if there is a relapse; other companies consider each situation individually and may offer the individual another chance at treatment if the individual is a valued employee and has made an effort to stay sober (this is the policy at CG). I think EAP's have been a big help in encouraging management to consider alcoholism as an illness and consider individual needs.

On the other hand, those of us in the alcoholism/EAP field need to clean up our act if we are to maintain credibility and ensure effective treatment for the alcoholic. A treatment program official recently told me of a proposal made to him by a so-called Employee Assistance consultant. This consultant stated he would agree to send all of his identified alcoholics to that particular treatment center in return for $200 per patient under the table.

Another example of questionable activity is the alcoholism treatment center that offers "Employee Assistance services" at nominal cost or, in some cases, free of charge. It is obvious to me and my colleagues with whom I have discussed the situation, that this is merely a front that allows the treatment program to filter alcoholic patients solely into their treatment center.

There is also "bandwagonism" in the Employee Assistance business. I don't mean to imply that this is a widespread practice, but I do know that there are some individuals and organizations operating in the Employee Assistance field whose sole objective is to get as many dollars as fast as possible. As an example, companies are buying EAP services that are nothing but an "800" telephone number where the employee never sees anyone that is an EAP "staffer." This is not "better than nothing" as some have argued. It is a rip-off that lets a company state that they have an EAP, but worse than that, it is unfair and may be damaging to an employee. A community mental health hotline is at least local and more familiar with resources than someone contacted through the "800" number who may never have even visited the area. If an alcoholic or an alcoholic's spouse is calling this "800" number, they could be talking to someone who has never dealt face to face with an alcoholic and probably never had any formal training in dealing with the alcoholic or a significant person in the alcoholic's life. Companies who buy this type of program are paying lip service to having a truly beneficial program, and those that provide it are short-changing the alcoholic.

There are some outstanding EAP services, available in-house or through private consulting organizations, but if we are ever going to control the costs for alcoholism treatment, whether it be for the elderly through Medicare or through other third party payers, then the alcoholism/EAP field and corporations throughout the country must take a stand and absolutely require proper service and ethical behavior.

Finally, I hope that you will strongly support Medicare coverage for treatment programs that provide the best opportunity for recovery for the elderly alcoholic. The alcoholic generally will use any excuse to not enter treatment; for the elderly, the cost may be truly prohibitive. I think a system of outpatient centers, covered under Medicare, would be an important feature of the program: they would be less frightening and disruptive for the elderly, and they would be less expensive for the government than in-patient treatment or the costs incurred by problems that arise when alcoholism is left untreated. Coverage for quality inpatient and outpatient programs is needed and makes good business and human sense.

Senator **Durenberger**. Do either of you know any good insurance policy coverage for alcoholism that we ought to adopt as a medicare model? Do either of your companies or any other policies out there really hit the button on the head, and all we have to do is pick it up?

Mr. **Sapp**. Our company provides for our employees 45 days full payment per year for the alcoholic in inpatient treatment facility. There are certain criteria we use as far as which facilities are covered, but in effect almost any of your well-known comprehensive treatment programs would be covered.

The reason we put the 45-day limit on it, one of the reasons is that I think it's important that you not allow the alcoholic to continue to revolve in treatment. That is as good inpatient treatment coverage as I know of.

Senator **Durenberger**. What do you do about cost sharing?

Mr. **Sapp**. Pardon?

Senator **Durenberger**. What kind of cost sharing do you have?

Mr. **Sapp**. As far as what the employee has to pay?

Senator **Durenberger**. Right.

Mr. **Sapp**. None.

Senator **Durenberger**. Is cost sharing unnecessary?

Mr. **Sapp**. I don't think it's necessary. I think it is just as appropriate to have a time limit on it because, if that employee does not get sober over a period of time, we won't give him continual cracks at treatment. Sooner or later we will say to him or her, "If you don't do something about your problem, you're not going to be employed at Connecticut General any longer."

Senator **Durenberger**. But I can't do that with elderly. You've got that kind of leverage, and I don't have that.

Mr. **Sapp**. Yes. And that is one of the problems.

Senator **Durenberger**. Well, let me ask you both about cost sharing. Has it got any merit to it at all? Is there any way to put the person at risk in some way? Or is there any way to promise the provider *x* number of dollars, and that's all they are going to get?

Dr. **Graham**. Let me respond to the first question, if I could, on insurance policies.

Our employees, and all our insureds, parenthetically, that is, people who don't work for us for whom we write insurance, have inpatient treatment benefits of at least 45 days yearly. There are some policies, depending on State mandates, that will have no limitations. But that's a minimum for all policies we write.

We also will pay for treatment in a freestanding alcoholism treatment program or for outpatient treatment. Our outpatient limits are now $1,500 a year. And it does not come under the mental health exclusions that may be in the contract. We define alcoholism outside of the mental and nervous system benefits exclusions of some policies that we have.

The freestanding programs or alcoholism treatment centers, our criteria are J.C.H. accredited or State licensed and approved. It's a pretty broad brush, saying that we feel that most State authorities that have some sort of approval program probably will have fairly good criteria. It's a trust exercise, but we feel that strongly about wanting alcoholism treated rather than to keep paying for the costs of untreated alcoholism.

In terms of incentive, I've not thought through a lot of that. I know that in our policies currently, health insurers have lost a bundle. The Federal Government is not alone in terms of having lost money.

Senator **Durenberger**. Some of that comes from mandated benefits, though, does it not?

Dr. **Graham**. I think not. I think some of it comes from real ignorance. I hate to say that as an insurer, but there is a myth that we have information. Kemper has been paying for alcoholism treatment since 1964. I can't tell you how many people have availed themselves of that. I can't tell you how much we paid for coronary bypasses last year. Our industry doesn't keep how much money comes in and how much goes out. We don't have a good handle on where does that money go, and I think that has been a real problem.

We have used the least cost-effective models. We are trying to do some things in product design, for example, with coinsurance, making it variable for various options. If you were to have a hernia repaired, for example, at an outpatient surgical clinic, which are well recognized to be efficacious in some cases, in some individuals, the company would pay for 90 to 95 percent of that procedure. Were you to have it in a hospital it might pick up only 80 percent and make you pay 20 percent or 25. That would encourage you to look at the option, at least.

Now, if your surgeon said you can't have it done there because of your heart, you know, if we have to have you in a different situation, or whatever, then you would accept that.

Senator **Durenberger**. Did you say in your earlier testimony you thought State legislation mandating benefits was a good idea or not a good idea?

Dr. **Graham**. I didn't express an opinion. I shall.

Senator **Durenberger**. Please do.

Dr. **Graham**. If I might. It is an opinion. I must state, of my company personally. My company is a member of HIAA, and I know that they oppose mandated insurance. I feel that States that have mandated insurance coverage, in fact the figures are there, they have demonstrated that effective treatment is available in those States.

There is a recent S.C.M. publication for NIAAA that I saw that shows money spent in States, comparing and contrasting those 17 that have mandated versus those 16 that have required options and those that have no insurance coverage. There is no question that States that have mandated coverage, alcoholism treatment occurs there.

Senator **Durenberger**. Well, I don't have any doubt about that; I just wonder if it is any more effective in those States than anywhere else and what you are giving up by mandating coverage. Have any of those States really measured the cost, the overall cost, of mandated benefits to the purchasers of insurance policies with mandated benefits, and what other kind of health care are you not getting because of the existence of mandated benefits? I think that's the HIAA argument.

Dr. **Graham**. Yes. I keep thinking that insurance caring for alcoholism treatment, treating the primary illness is going to save money. I'm just dumb enough to think that if a person has a primary illness, it needs treatment. The diabetic, for example, could be given mustard plasters or corn salves, or something, for their peripheral circulatory problems, but it would be more efficacious to treat—and it's not even the primary disorder—but at least to give them insulin.

Senator **Durenberger**. All right.

Mr. Sapp, do you have any comments on mandated benefits?

Mr. **Sapp**. No, only that our experience has been, at least in Connecticut, that it is very rare that you get to the mandate. I don't know of but one client in the last 2 years that has used the full 45 days, for instance, per calendar year. So it's very rare that you get to the limit

Senator **Durenberger**. I have one last question that relates to the alternatives available to inpatient care. Do you generally agree with the testimony we have had here today in terms of the fact that reimbursement systems, whether it is ours or yours, if properly structured could provide alternatives to inpatient treatment?

Mr. **Sapp**. Absolutely. You know, an alcoholic comes into my office now, and if he or she also has financial problems, which most alcoholics do have, they are financially irresponsible generally speaking, then I look at adding another financial burden to them by sending them to a place that isn't covered. So rather than do that I will turn around and send them to an inpatient treatment program that is fully covered by Connecticut General at much more expense. So the alternative is certainly needed, and I think certainly for the elderly it is.

Senator **Durenberger**. All right.

Dr. Graham?

Dr. **Graham**. I would not cast a stone at Connecticut General. I don't mean to do this. But I want to tell Chuck there is hope; and that is, the reason we began to pay for treatment in freestanding or quality outpatient programs was because of our director of our personal assistance program. He said to management, "Gee, it makes sense that people can get well with a choice of treatment." And the company understood that. So they may listen to you eventually.

Mr. **Sapp**. No. Let me say something else. The facility I mentioned early on, I do have an exception for our employees for coverage there. So I would fully agree that we need some flexibility; but in a general sense there is need for coverage for outpatients.

Dr. **Graham**. I think, as we heard in previous testimony, that the levels of care will be something that I don't think you will be able to address by saying—I guess you could do whatever you wish, but I hope that you would not say—"Here is going to be medicare's coverage for alcoholism: You will go only to an outpatient program." Period. Do not pass Go, and so on. I think to have a flexible system, it can best be utilized.

One of the nice things about outpatient treatment is, if it doesn't work there is a fallback position that is residential care, whether in freestanding or hospital based. And that's a nice option. If it works—great.

Senator **Durenberger**. I thank you both very much for your time.

The hearing is adjourned.

[Whereupon, at 4:45 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

TESTIMONY OF DR. BARRY S. TUCHFELD

Before the United States Senate
Committee on Finance
Subcommittee of Health

Presented on July 20, 1982

Senators, Ladies and Gentlemen:

My name is Dr. Barry S. Tuchfeld, I am an Associate Professor of Sociology at Texas Christian University (TCU) and Director of the Center for Organizational Research and Evaluation Studies ("The Research Center"). I received my Ph.D. from the University of Tennessee, Knoxville in the discipline of Sociology and conducted my doctoral research on social psychological and hormonal correlates of situated alcohol use in social settings. Since that time my primary area of interest has been in recovery processes associated with alcoholism. From 1974 to 1976 I was employed with the Research Triangle Institute in North Carolina and have been with TCU since that time. I have conducted numerous studies for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse and have served on various review committees for different government agencies, including the Health Care Finance Administration.

The Research Center employs a multi-disciplinary staff, all of whom have advanced degrees in the social sciences. During the last eighteen months The Research Center has been primarily engaged in evaluations of alcoholism treatment and an epidemiological study of alcoholism for the State of Texas. The Research Center is one of the largest research centers actively conducting research on the treatment and evaluation of alcoholic persons. Our funding is approximately $600,000 annually, including grants and contracts from public and private sources.

Since August of 1978, Schick Hospital has provided funds to TCU in order to conduct a comprehensive and independently controlled evaluation research project known as "Alcoholism Treatment Research Study" (ATRS). When I was originally contacted by Dr. Prud'homme, Executive Director of Schick Hospital, I was pleased to learn of the Hospital's openness and commitment to finding out more about the effectiveness of its treatment program in a systematic manner, and to the incorporation of the project as an ongoing part of the Hospital's activities.[1] From early 1979 to mid-1980, we compiled an extensive baseline and treatment process data set that would serve as a basis for evaluating treatment effectiveness of patients six and eighteen months after their admission to the Hospital. Follow-up interviews were then conducted at the six and eighteen month post-admission dates.

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[1] Please refer to Appendix A.1 in the technical report which is the original Agreement between Schick Hospital and myself with regard to my autonomy and right to publish these data regardless of the implications for the Hospital.

The Project Director of ATRS is Wendy L. Lipton. Ms. Lipton has a M.A. in Sociology from Duke University and is a Research Associate of the Center for Organization Research and Evaluation Studies. Her primary duties as Project Director have been to manage day-to-day operations of the Schick evaluation project (ATRS) and to maintain quality control of all aspects of the research.

During the one-year period of initial data collection, a total of 488 persons were admitted to the Hospital as new patients. A trained interviewer employed by TCU was located at the Hospital and was responsible for gathering information. Routine quality control procedures were implemented to insure the reliability of that data collection process. The data gathered from a population of 458 patients included patient interviews, interviews with staff, interviews with family members, collection of information from physiological records and administrative records. As Principal Investigator of the project, it was my responsibility to insure that all conceptualization, measures, data collection methods and statistical analyses were implemented in a scientifically sound manner.

Data have now been collected from patients who have been through the treatment program at both six months and eighteen months post-admission. In my experience, no study in this field has achieved a higher response rate than achieved in our study. Eighty-two percent of the patients in the study were interviewed six months post-admission, and seventy-eight percent of the patients in the study were interviewed eighteen months after their admission dates. Throughout, we maintained extensive quality control checks to maximize the overall integrity and reliability of the data that we collected.

The current investigation extends previous research efforts in both substance and analysis. For example, the broad policy focus of the well-known "Rand Report" (Armor et al., 1978; Polich et al., 1981) seriously undermines the value of their analysis of treatment effectiveness for inpatient facilities. Their data on hospital-based, inpatient programs were based on only 59 patients from different types of hospital programs (see Armor et al., 1978: 124-151). Such a data base is too small and confounded to provide reliable research data or findings (Emrick and Stilson, 1978). Unlike the Rand Report, the present study provides more indepth analyses of hospital-based, inpatient alcoholism treatment. Since the Rand data are not sufficient to provide meaningful conclusions regarding hospital-based, inpatient treatment effectiveness, the Rand Report cannot serve as a comparative basis for the present research.

Details of the methodology and data collection processes are included in the preliminary technical report which is entitled "ALCOHOLISM TREATMENT RESEARCH STUDY: An Evaluation of Treatment

Outcomes 18 Months Post-Admission to Schick-Shadel Hospital of D/FW, Inc." ("Report") provided to the Subcommittee. I would like to briefly summarize some of the initial findings of our analysis. I will refer generally to certain tables that are contained in our Report.

The patient population of this Hospital can best be characterized as a chronic and severe group of alcoholic persons. While there are differences among patients with regard to prior treatment history and the extent of their problems, by any recognized standards, the group would be characterized as being classically alcoholic. These conclusions are extracted from Table A.1 in the Report which illustrates the amount of alcohol used, the extent of behavioral impairment, family problems and job problems, as well as some consideration of their drinking pattern prior to admission and the length of time they have been drinking heavily. It is worthy to note that over three-quarters of the patients admitted to Schick Hospital had made previous attempts to stop drinking by themselves and over one-half had had some type of prior alcoholism treatment experience before entering the Schick treatment program. The population is predominantly male, white, age thirty to sixty, mostly married and over one-half had attended or graduated from high school. However, in keeping with the conventional wisdom promoted by NIAAA, that anyone can develop alcoholism, the demographic distribution of the patients studied is such that they could be said to come from all walks of life and from a wide variety of social backgrounds. Our analyses indicate no bias in the sample interviewed with regard to the severity of alcoholism. There was a slight bias toward married (vs. single) people.

While it is an oversimplification to talk about one all inclusive effectiveness rate of any treatment program, it can reasonably be argued that the Hospital's treatment program effectiveness rate across a number of criteria vary between approximately fifty percent and sixty percent. In general the effectiveness of the treatment program appeared consistent across any number of patient subgroups. For example, there were few differences among patient subgroups indicators such as educational background and employment status. It is important to note in the present inquiry that persons sixty years of age or older appear to have a higher level of sustained abstinence at the eighteen month interview. In order to reach these conclusions, a great deal of analyses were done to ensure that the findings were relatively stable across patient subgroups.

We have also conducted more indepth analyses of treatment effectiveness based on complementary outcome criteria. These criteria include: (1) average ethanol use per drinking day, (2) average alcohol-related behavioral impairment, (3) average alcohol-related job problems, and (4) average alcohol-related family problems. These data allow baseline (admission) and 18-month follow-up comparisons across drinking status categories. Across all outcome criteria, each patient subgroup showed substantial improvement at 18 months post-admission regardless of their drinking status.

A question that is often raised in the evaluation of alcoholism treatment programs is whether or not the treatment program itself was a critical component in the recovery process. Looking at the data in an overall manner, there is strong evidence that the changes being observed among patients maintaining their abstinence are reasonably attributable to the Schick treatment program. The logic of this argument is based on extensive analysis of patient characteristics and attributes which suggested that the findings were relatively stable across groups at eighteen months post-admission.

A major finding of the Study was that persons who had followed the prescribed treatment regimen of an initial inpatient treatment stay followed by at least two abbreviated stays at the Hospital were substantially more likely to be abstinent from alcohol at eighteen months post-admission than those who did not adhere to the treatment prescription. In particular, fifty-nine percent of the patients who completed the entire treatment regimen were abstinent at the eighteen month follow-up interview. This compares with only thirty-five percent of those patients who did not follow the prescribed treatment regimen. I think this is an issue of extreme importance because, as with any type of intervention, the institution can only do so much in extending and offering its services. In order for any treatment to have a chance to succeed, the patient must make the decision to adhere to the treatment prescription.

One of the important consequences of this observation is presented in Figure E of the Report. These data suggest or indicate that those persons who did not minimally complete prescribed treatment regimen of Schick Hospital were far more likely to utilize other treatment services I would suggest that this observation has potentially important implications for the value of the continuity of care program and its effectiveness as offered by Schick Hospital.

Analyses were conducted regarding the effect on the patients of other treatment utilization both prior to and after the initial inpatient stay at the Hospital. While I am not implying that Schick is the only effective treatment for many patients, it is clear in Table E of the Report that our initial findings indicate that utilization of other treatment regimens does not necessarily contribute to patient well-being at eighteen months.

In addition to descriptors of patients at baseline and outcome we also collected considerable information about the treatment process and experience itself. During our preliminary analysis of what patients saw as the most important treatment component we observed a substantial emphasis by patients on the role of aversion treatment to their recovery process. These observations are charted in Figure D of the Report. Among abstainers, almost half identified the aversion therapy as the most important part of the treatment program both at admission and after eighteen months. While "drinkers" also rated aversion as most important at baseline, they ranked this component much lower at eighteen months. Instead, drinkers ranked counseling as the most important component at eighteen months. Interestingly, while the drinkers' eighteen month perception of counseling was higher than education, the reverse was true for abstainers. Patients who were abstainers at eighteen months ranked education slightly higher than counseling.

The highlights of our initial analysis should be viewed in light of the considerable amount of time, effort and expense that has been expended to produce a comprehensive data set and to subject and expose it to sophisticated data analysis. Future analysis will expand our initial observations as to extract intricacies that may further increase the sensitivity of our understanding of the recovery process. Our strategy from the beginning has been to investigate alternate hypotheses that might serve to explain the observed effectiveness of Schick's treatment program. Our preliminary analyses indicate that neither patient attributes nor prior treatment experiences explain maintenance of soberity over time. Consequently, our findings provide eivdence that Schick treatment intervention may be instrumental and perhaps a critical element in helping patients to stop drinking as well as in maintaining that abstinence through time.

It is also important to note that the treatment program appears to have a substantial positive effect even on those who do not entirely stop drinking. This is indicated by reduced levels of alcohol use and a decrease in alcohol-related behavioral and social impairment. It might be argued that the treatment program, by virtue of its comprehensive approach to the treatment of alcoholism, may provide the opportunity for a person to at least briefly or intermittently modify his or her drinking behavior and thus begin to resolve problems in other life areas. However, this does not imply that these persons are drinking in a controlled manner as they still exhibit alcoholism-related impairments, albeit at a reduced level.

Of course, no single study of alcoholism treatment can answer all questions with certainty. The comprehensive nature of this data set have and will continue to permit more sophisticated analyses than are usually done in the alcoholism treatment field. The data set also reflect the commitment of the Hospital in Fort Worth to expose itself to extensive scrunity in order to further improve its treatment effectivness. While future analysis will focus on complex multivariate modeling, the present analysis actually approximates that stragety. Based on our initial analyses, we are encouraged that we are in the process of increasing the understanding of the dynamics of the resolution process among alcoholic persons.

In closing, I would like to take this opportunity to thank the Senate Subcommittee for hearing about the preliminary results of this very timely and important research. I would like to state that it is not being unduly academic to explain that the evaluation of alcoholism treatment is a relatively recent phenomenon and few studies exist that withstand reasonable scientific scrutiny. My reason for making this point is that alcoholism treatment itself is a relatively recent phenomenon. Until we have substantially improved our understanding of what treatment works best for whom, the potential consequences of retarding alcoholism treatment programs that can demonstrate effectiveness would seem, in my professional judgment, to be a dangerous strategy. The complexity of the issues associated with understanding alcoholism treatment and resolution processes simply do not justify gross simplicity of the ever more popular bottom line answers nor would I assume that the Subcommittee would appreciate any oversimplification that tended to do injustice to their already intense efforts. Consequently, at the risk of providing information that can at some times appear unnecessarily detailed, I have presented a brief view of the nature of the data that we have collected and the logic of skepticism and alternative explanations that we have incorporated. Even from this critical perspective, our current analyses provide evidence that the treatment program is having substantial effects on numerous types of alcoholic persons and is increasing the opportunities for those persons to live in a socially productive and meaningful way.

TESTIMONY OF JAMES W. SMITH

Before the United States Senate
Committee on Finance
Subcommittee of Health

July 20, 1982

Senators, Ladies and Gentlemen:

My name is James W. Smith. I am a physician and Medical Director of Schick Shadel Hospital in Seattle, Washington.

Schick Shadel Hospital is one of three licensed and fully accredited medical hospitals, collectively known as Schick Hospitals, engaged in the diagnosis, research and treatment of the disease of alcoholism under the supervision of qualified non-psychiatric physicians.

Besides Schick Shadel in Seattle, the other two Schick Hospitals are located in Santa Barbara, California and Fort Worth, Texas. Together, the Schick Hospitals can treat up to 120 patients at a time and, to date, have treated over 40,000 victims of alcoholism.

Each of the three hospitals is separately incorporated and all are wholly owned subsidiaries of Schick Laboratories, Inc., which is 98.6% owned by Frawley Corporation. The Frawley Corporation is a public company, the majority of whose stock is owned by its founder Patrick J. Frawley, Jr.

I am an officer of Schick Laboratories of the Frawley Corporation and am on the Board of Directors of all three hospitals.

The Schick Hospitals are not affiliated with or related to any other chain of hospitals engaged in alcoholism research or treatment.

History of Schick Hospitals

Well over forty years ago, two individuals by the names of Charles Shadel and Dr. Walter Voegtlin began to study the obvious similarity between the automatic behaviors which result from Pavlovian conditioning and the apparently automatic resumption of destructive drinking which characterizes alcoholism. Dr. Voegtlin had been a colleague of Dr. Pavlov and he created a series of experiments to see if specific treatments, designed to extinguish Pavlovian conditioned reflexes, would help detoxified alcoholics avoid relapsing into drinking.

The two created a setting replete with alcohol-related visual stimuli. The patient was presented various alcoholic beverages. The seeing, pouring, savoring, smelling and tasting of alcoholic beverages was repeatedly coupled with an unpleasant sensation. Nausea was the unpleasant sensation with which the sight, smell and taste of alcoholic beverages was associated. Later, an alternative technique using a stinging sensation to the skin, usually of the forearm, produced by a tiny electric current was developed to produce an easily timed and modulated unpleasant sensation.

In 1935, the Schick Shadel Hospital was created. For the next thirty years, it refined the treatment of alcoholism and developed and adapted various other techniques to complement the counterconditioning concept.

In 1964, it attracted a new patient, Patrick J. Frawley, Jr. Mr. Frawley was at the time the Chairman and Chief Executive Officer of the Schick Safety Razor Company and had an interest in a number of other well-known enterprises. He also had a drinking problem.

Mr. Frawley, in a letter dated July 20, 1982 to Chairman Durenberger, describes what happened next:

> "After my first treatment of the 10-day counter-conditioning program, I noticed an immediate relief from my compulsion to drink. A month later I was astonished to find that I still had no desire for any of my favorite alcoholic drinks, a condition that has persisted to the present time.
>
> "I was so impressed by this effect on me that I discussed the matter with the directors of the Schick Safety Razor Company. They selected a committee to study the effectiveness of the treatment. One of the committee members, the late General Thomas S. Power, former commander of the Strategic Air Command, consulted with Dr. Dean Wooldridge, one of the founders of Thompson Ramo Wooldridge, who encouraged our entry into the addiction field. Dr. Wooldridge, a physicist, is the author of Machinery of the Brain published by McGraw-Hill which is required reading for twenty different courses at Stanford University. Dr. Wooldridge was very positive about the effectiveness of counter-conditioning in changing habits. The committee members were also very impressed with the long-term, positive results of the enthusiastic comments of former patients. As a result, the Schick Safety Razor Company purchased the hospital and developed a subsidiary known as Schick Laboratories."

Treatment at Schick Hospitals

My colleague, Dr. Eck Prud'homme, Medical Director of Schick Hospital in Fort Worth, has addressed this Subcommittee on the medical aspects of alcoholism and the treatment which Schick patients receive to arrest the disease. I will not reproduce that testimony here but incorporate it by reference.

However, as Dr. Prud'homme pointed out, the treatment at Schick is one that is constantly under study by our own doctors and scientists, as well as others, to increase the 59.3 percent success ratio. I would like briefly to address that point, i.e., this continued research into bettering the product of alcoholism treatment.

No institution can achieve its goals without long-term commitment to study of both its market and the quality of the product it makes available to the public. This is especially true in the private sector. To date, Schick has made such a commitment and has expended over $6,000,000 to study alcoholism and other addictive behaviors. A thirty-five-person staff of doctors, scientists and assistants brought the treatment process to its present level. The treatment is neither a fad nor quackery. The $6,000,000 of research cost has not been recovered by Schick, either through public or private grants, or passed through to patients.

The research done at Schick is more than promising. It has shown itself successful in almost 60 percent of the people who have taken the full treatment. Continued research is required to increase the success rate even further. Yet, it is unrealistic to expect the private sector to continue to expend such funds of its shareholders and make long-term research commitments when the sword of destruction hangs over its head.

Medicare spends $100 million a year in alcoholism-related diseases. As the Subcommittee's Press Release points out, the total dollar cost to society attributable to alcoholism is well over a thousand times that a year. In the last half century, Schick has treated over 40,000 patients and out of its own funds has developed a treatment modality which is successful for almost 60 percent of those who take the complete treatment. Using the press release's figures on alcoholism, this treatment, if extended to the population at large, could save over $65 billion a year. Yet, instead of being encouraged by government and the insurance industry, the private sector is being compelled to question the wisdom of doing further research and committing additional funds. When threatened because of Medicare cuts and denials of insurance coverage, it faces a reduction in the number of patients who can be treated.

Clearly, there is something wrong here.

TESTIMONY OF ANN WINDHAM WALLACE

Before the United States Senate
Committee on Finance
Subcommittee of Health

Presented on July 20, 1982

Senators, Ladies and Gentlemen:

My name is Ann Windham Wallace. I live in Austin, Texas at 1106 West Sixth Street. I am fifty-six years of age. I have recently been employed in the Office of Appointments for the Governor of the State of Texas, and I am now serving on the Committee for the Reelection of Bill Clements as Governor of Texas. I am testifying before you today as a witness to the effectiveness of the alcoholism treatment program offered at the Schick Hospital in Fort Worth, Texas.

I was treated at the Schick Hospital for chronic alcoholism in October of 1977. I have not had a drink since that treatment. For nearly five years now, through numerous personal trials and difficulties, including a difficult divorce, I have been able to abstain from the use of alcohol due, in a very large part, to the treatment that I received at Schick.

My dependence on alcohol developed so gradually that I cannot even now say when alcohol became necessary in my daily life. Not until I was over forty years old did I drink both regularly and heavily. For the four or five years prior to admission to the Schick Hospital, I was drinking all day, every day.

By the Spring of 1977, I was very disgusted with myself. I would and had to drink the entire time that I was awake or conscious each day. I would drive at night in such a condition that I had to close one eye to keep track of the center line of the road. I would wake up the next morning terrified by the fact that I had driven, and I was disgusted with my general behavior. It was about this time that I decided to quit drinking. I soon discovered, however, that I could not quit or even cut down on my drinking, even though I very much wanted to do so.

I consulted my internist about my drinking. I was admitted to a general hospital in Fort Worth for detoxification and remained there for approximately a week. At that time and thereafter through the rest of the Summer of 1977, I was treated by a psychologist and had some success in stopping drinking during that time. I did, however, again take up drinking wine and, for a while, seemed even able to control my drinking. Within a short time, though, I found myself in certain situations in which people were drinking heavily, and I began drinking again--first a little and then a lot--and could not stop.

I decided on the advice of a friend to try the Schick Hospital treatment program. I visited the Hospital prior to treatment and decided that that was what I wanted to do. My then husband, who was a medical doctor, refused to admit that I needed help and refused to pay for any such treatment. I did not have sufficient personal funds at my disposal at that time to pay for the treatment, and I did not want my family to find out, so I could not ask to borrow money from family members. I found out, however, that the treatment would be paid for by my insurance. That was the only thing that allowed me immediately to admit myself for treatment at the Hospital.

Personally, I think the entire treatment program at the Schick Hospital and the in-patient group setting are both important to maximizing the effect of the treatment program for the patient. However, I must say that I do not think that I would have stopped drinking or that I could have continued without drinking for these five years without the aversion therapy that is part of the Schick program. This was made poignantly clear to me as recently as last summer. After enduring a divorce trial in Fort Worth, I really wanted and needed a drink during my return flight to Austin. I had decided that I was going to have that drink and possibly keep drinking at least until my divorce was final. However, when the stewardess served a drink to the gentleman sitting next to me, my stomach started to churn and I felt the effects of the aversion therapy returning. It was that feeling that kept me from ordering that drink and allowed me to think more rationally about my conduct. I truly believe that it was only the effect of the aversion therapy that kept me from returning to a regular pattern of alcoholic drinking.

I believe that alcoholism is a disease from which I presently suffer. The Schick treatment has enabled me to control that disease by not drinking. So far as I know, there is no cure for this disease, and the best that we know how to do at this time is to control it. Today, I am an active, productive, contributing part of the social and political community in which I live. I was a confirmed alcoholic and I knew it. I had already begun to damage my liver through drinking, and either because of physical or psychological complications I do not feel that I would be alive today if I had not been able to stop drinking.

Thank you.

TESTIMONY OF L. GORDON SMITH

Before the United States Senate
Committee on Finance
Subcommittee of Health

Presented on July 20, 1982

Senators, Ladies and Gentlemen:

My name is Lowell Gordon Smith. I live at 319 Heather in Conroe, Texas.

I would like to thank the Subcommittee and staff for the opportunity that you have given me to testify before you today. I have a lengthy history of alcoholism for which I have received treatment at Schick Hospital and that I now have under very good control. Since my treatment for alcoholism, I have been very interested and active in helping other alcoholics to stop drinking. I understand that the Subcommittee is interested in hearing from people who have received treatment for alcoholism. I have undergone a program for the treatment of alcoholism which program I believe to be a very successful program for long term chronic alocholic drinkers.

In 1970 I helped to start a business in Houston, Texas related to the Oil industry. In the eight years that I was with the Company it grew to approximately one hundred twenty-five employees. In 1979 I was the Executive Vice-President of the Company and the chief financial officer. At that time I enjoyed salary and other benefits worth approximately $120,000 per year. My job was a very rewarding, responsible, well-paying job. Despite all of that, I had planned to quit that employment at the end of 1979. My desire to quit was not because of the ability to move to other employment, but rather because I knew I could no longer handle the responsibilities of my position and I had decided to retire to a life of full time drinking. I was thirty-eight years old. Because of certain oil ventures in which I had been able to participate along with the Company, I had royalty income sufficient to support myself and had decided to quit working. That decision was made for me, however, when the Company that I had helped to start and had worked for so hard for so many years terminated me solely because of my continued drinking.

I began driniking at the age of fifteen years. Almost from the onset, I had been a heavy drinker, and was drinking approximately a fifth of whiskey a day in my later drinking years. This drinking lead to numerous problems not only with my employment but also with my family life. My first marriage of eleven years ended in divorce simply because my wife could no longer stand my drinking. I remarried only to have that marrige end in divorce. The divorces and the numerous separations prior to divorce in each marriage were a direct result of my drinking. Whenever a choice finally had to be made to stop drinking or end the marriage, I could not, even in light of that terrible choice, make myself stop drinking.

On numerous occasions during my second marriage, I went into the Alcoholics Anonymous program. I must admit that my participation was primarily to relieve pressure that my wife had put on me. However, many times I walked through the front door of the AA meetings with the true intent and desire to quit drinking. Sometimes I was able to quit for a week, sometimes three weeks, sometimes three months. One time I was able to quit for almost a year. Yet, every time for me, it did not last and I would ultimately return to drinking. I went into the Schick Hospital on December 6, 1979. I am not generally very good at remembering dates but that day is four days before my thirty-ninth birthday and also happened to be my son's birthday. My son, to this day, remains excited about that date and often expresses the statement that he and his father now have the same birthday.

The Schick treatment program was very helpful to me and gave me the tools to stop drinking and to continue not to drink. I personally feel that nothing less than the aversion therapy that I received at Schick would have stopped me from drinking. I found the narcotherapy to be a booster of the positive side of me. Tapes were made of the therapy sessions and I still use those tapes today and they are very meaningful to me. Listening to those tapes, I can see the progression that I made during my treatment in attitudes and outlooks as I realized the kind of growth that I was going through.

Ultimately, I think both the aversion and the narcotherapy were necessary. The aversion helps me not to do something, that is drink. I never want to forget why not to drink, but I also want to always express the positive side of why to stay away from drinking. Of the two sides, the long-lasting soberity that I have obtained is in and of itself the strongest reason for my continued control of alcoholism. You may hear from many experts concering their opinions about different treatment programs and the effectiveness that those programs have for different people. I am not an expert on the treatment of alcoholism. I can, however, tell you that I have lived with alcoholism in my life for over twenty years and the treatment that I received to control my alcoholism worked and continues to work.

Prior to my treatment, my life priorities were first drinking, second work and last family. Today my priorities are family first, not drinking second and third my business.

Since getting my own alcoholism under control, I have worked with many other alcoholics. I know what drinking does to a person and I have seen the waste that drinking can make of a person's life. The waste I am talking about is the waste of human talent and human lives. In my own case, my wasted life was turned into a productive life in both an economic and social sense. Prior to my treatment at the Schick Hospital my life was at a point where decisions had to be made for me. The only decision I was capable of making at that point in time was the simple decision that I needed help and that I could not help myself. I have since that time begun a new company which is a firm that provides accounting services to small businesses in the Houston area. I started the company in August of 1981 and I now have six employees. By the end of my third year of operation, I fully intend that the company will employ at least twenty persons. I feel that my personal life productivity as well as the success of my business and the jobs, taxes and services that it provides to my community are the strongest testimony that I could give in favor of the continued availability of treatment of alcoholism for people of any age.

My major contribution to society in the year prior to my treatment at Schick Hospital was a personal and business contribution to Houston's drinking establishments of approximately $36,000. I like to think that through my volunteer efforts, my company, and my personal and employee taxes, I will contribute much more to my community in a much more positive way.

Once again, I thank each of you for granting me this opportunity to testify on behalf of the Schick Hospital treatment program.

SUMMARY OF THE TESTIMONY
OF
JAMES W. DUNN, JR.

Mr. Dunn is a resident of San Antonio, Texas. Mr. Dunn testifies in his statement concerning his disease of alcoholism; his successful treatment for that disease at the Schick Hospital in Fort Worth, Texas; and the vast imporvement in his life since that treatment.

TESTIMONY OF JAMES W. DUNN, JR.

Before the United States Senate
Committee on Finance
Subcommittee of Health

Presented on July 20, 1982

Senators, Ladies and Gentlemen:

My name is James W. Dunn, Jr. I live at 5143 Prince Valiant in San Antonio, Texas. I am forty-one years of age. I am married and have three children. I am testifying today as a recovering alcoholic who has undergone treatment at the Schick Hospital in Fort Worth, Texas.

My story is not at all unique. That, however, is why I feel that it is so extremely important.

For many years prior to going to Schick, I was a serious alcoholic drinker. I did not drink constantly and I generally drank beer, but three or four times a week I was drunk. I had numerous fights at home when I was drunk. My wife left me because of my drinking. I could not get along with my children when I was drunk. My drinking often led to blackouts, and I have many memories of waking up at home in the morning, knowing that I had driven myself home but having no idea how I had done it. I was terrified by the thought of what I could have done to myself and other people because of my condition.

Prior to going to Schick, I had voluntarily admitted myself to a nonmedical treatment center. At that treatment center, I received thirty days of intensive lectures and counseling about alcoholism, and they attempted to lay a groundwork for me to stop drinking. After the thirty-day program, I attended Alcoholics Anonymous regularly, and I still attend regularly to this day. But, despite the treatment and the continued support of my group at AA, I went right back to drinking within a relatively short period of time.

As we all know in the world of alcoholism, an alcoholic may stop drinking for a period of time, whether it is two weeks or ten years. But we also know that alcoholism is a progressive disease. We know that, within a month or two of going back to drinking, the alcoholic will be in the same position as far as tolerance or nontolerance and levels of drinking as he had been prior to his period of nondrinking. The use of alcohol simply waits for you, and, as soon as you take that first drink, it is right there saying, "Welcome back!" and picks up right where you were before. This is what happened to me not long after my thirty-day counseling treatment.

After I began drinking again, I soon attained the same level of drinking. I continued to drink for a year or so after that, even though I desperately wanted to quit drinking most of that time. I tried to quit drinking, but I absolutely could not quit drinking.

I was fortunate enough to have the occasion to meet a very dear lady who I consider to be a very close friend. She was then working as a representative for Schick Hospital in the San Antonio area. After a period of time, my problems were just as severe as they had been previously, and I was again experiencing blackouts from my drinking. One particular Monday night, I again got drunk. When I woke up the next morning and entered the kitchen of my home, there sat the Schick representative and my wife, who proceeded at that point to do what is called an "intervention." They bring before you written notes of your behavior and failures and the problems that your drinking has caused for the last few weeks and discuss with you your need for treatment and the reasons or lack of reasons for not getting treatment. In my case, I was then unemployed and therefore able to go to Schick. The cost of medical treatment being what it is today, we were not in a position financially to pay for such treatment, but it was brought to my attention that insurance was available at that time to pay for the treatment. Looking back upon the situation, I believe that had insurance not been available I could not or would not have gone for treatment.

There have been some times in my life--as I feel there are in every life--that I felt depressed or saddened or remorseful about a particular situation. When I boarded the airplane out of San Antonio on my way to Fort Worth to the Schick

Hospital, I think that both emotionally and psychologically that was the lowest point that I have ever had in my life. I remember standing waiting for the plane looking at my wife and my friend, who had brought me to the airport, knowing I had a family to support, but I had a disease that I could not overcome. My self-esteem, my self-worth, and everything that was really meaningful in my life was at its lowest point.

In the ten-day period that I was at the Schick Hospital, I attended all of the lectures. I attended all aversion and narcotherapy sessions--five of each. Even though I had been admitted to a prior thirty-day, in-patient counseling program and had attended Alcoholics Anonymous where on many, many occasions in public meetings I have declared, "My name is Jim Dunn, and I am an alcoholic," I have to truthfully say that it was not until my treatment at Schick Hospital that I learned that I was truly an alcoholic. I did not hate my job; I did not dislike my city or my family. All of these excuses had no basis. I realized that I was an alcoholic and that alcoholism was a disease that I had. I was at a facility that was manned by professionals there to treat solely the disease of alcoholism. I learned that if I devoted my body and soul to their attention and direction, they could help me control my desire to drink.

I completed my treatment at the Schick Hospital, returned to San Antonio and, since then, I have attended the Schick aftercare activities as well as being active in Alcoholics Anonymous.

I feel that the aversion therapy, which is part of the Schick treatment, has been the strongest influence in helping me to maintain my sobriety. The smell of liquor, to this day, puts a jitter in my stomach and dredges up the memories of my condition when I was undergoing treatment.

I am happy to say that, at this time, I no longer have any urge to drink. I feel that drinking is a choice and that I have chosen not to drink in order to control the disease from which I suffer. Previously, I have had the urge to drink but have successfully applied the many techniques taught to me at Schick that keep me aware of my disease and aware that I continue to have the choice not to drink. I feel that the Schick treatment has given me that choice and ability to do something about my life. In the end, the great positive feeling that I have being sober on a day-to-day basis is the greatest reinforcement for my maintained sobriety.

I am very comfortable with my sobriety and my ability to continue to control my alcoholism. I have returned to a construction job that I previously held. It is a job that I very much enjoy and a job that involves a high degree of responsibility in supervising construction jobs.

I have returned to the same life that I previously had except for alcohol. I still work with many people who drink heavily, and, yet, even in their presence I am comfortably able to continue with my choice not drink.

In closing, I would like to say to you that I am an alcoholic. I have arrested my disease at this particular point and juncture in my life. I am very grateful to all of the people who have helped me in overcoming my problems in alcoholism. Had it not been for the possibility for me to get the treatment at a place such as the Schick Hospital, I would probably be drinking today.

Thank you.

Seabrook
House

Center for the Treatment of Alcoholism and Addictive Diseases

Statement for the Record of the June 27, 1982 Hearing on Medicaid Coverage for the Treatment of Alcoholism.

Submitted by:

Richard N. Ells, C.L.U.
Comptroller, Seabrook House
Center for the Treatment of Alcoholism and Addictive Diseases

In a press release regarding the Report of the National Association of Insurance Commissioner's Task Force (NAIC) on Alcoholism, Drug Addiction, and Insurance dated May 26, 1982, Task Force Chairperson, William P. Davis, Jr., is quoted as saying, " 'Insurance Companies are already paying for the side effects of alcoholism and other drug dependencies when care is provided in traditional hospital settings. But, treatment in free-standing centers, which in many cases are less expensive and more effective, is seldom covered' ". 1

Medicare, like many insurance providers, is currently reimbursing for alcoholism treatment provided in hospital based settings only. This is an extremely expensive alcoholism treatment alternative due to the high overhead costs of operating within a general hospital.

Free-standing treatment facilities are defined by the NAIC Task Force in the Model Benefit Structure for Alcoholism and Other Drug Dependencies as adopted on May 25, 1981 as:

> Affiliated with a hospital under a contractual agreement with an established system for patient referral; or Licensed, certified or approved as an alcohol or other drug dependency treatment center by the appropriate governmental agency; or Accredited as such a facility by the Joint Commission on Accreditation of Hospitals (or making progress twoard accreditation.) 2

I sight Seabrook House as an example of a free-standing alcoholism treatment center which, like many other free-standing facilities, fits not one of these criteria, as required, but all three.

I hope the Senate Finance Committee's Sub-Committee on health will consider the finding of the NAIC Task Force which was set up to provide a guide for the states, when determining the best course for federal Medicare coverage.

It is my firm belief, not only as an Alcoholism Service Provider, but also as a Medicare recipient since March 5, 1980, that Medicare should provide optimal health benefits at the lowest possible cost to the tax payer. As Mr. Davis has pointed out, alcoholism treatment in free-standing treatment facilities fits both of these criterias.

Reference:

1. State of Texas, Board of Insurance. Press Release June 12, 1981.
2. Report of the NAIC (C-1) Alcoholism, Drug Addiction, and Insurance Task Force, May 26, 1981. Section 1.1. a-c, Page 9.

LUTHERAN CENTER FOR SUBSTANCE ABUSE

A LICENSED SPECIALTY HOSPITAL FOR THE
TREATMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

John E. Keller, President
Lutheran Center for Substance Abuse
1700 Luther Lane
Park Ridge, Illinois 60068
(312)696-6050

SERVICES:

The Lutheran Center for Substance Abuse (LCSA) is a 94 bed specialty hospital for the concurrent treatment of medical and psychiatric conditions coexisting with alcoholism and/or substance abuse.

LCSA and Parkside Medical Services (PMS), members of the Lutheran General Medical Center, developed and have operational treatment services and programs that span five distinct levels of care. These levels of care are related to individual patient need and provide a spectrum of services from acute inpatient through primary outpatient treatment.

The services offered by LCSA include:
Inpatient:

1) 24 hour, seven day a week admission and evaluation/triage service.
2) a 20 bed evaluation-assessment unit which examines the patient's needs and determines the combination of program(s) and services best suited to meet these needs.
3) a 22 bed specialty care unit for patients with serious concurrent medical and/or psychiatric problems that preclude their participation in the standard treatment program.
4) 52 intermediate care beds providing conurrent treatment of medical/psychiatric conditions and alcoholism/substance abuse.

These inpatient services are available for adults and adolescents. Parkside Medical Services has an adult and adolescent alcoholism/substance abuse residential program for patients without serious medical/psychiatric conditions. Most youth are treated at that program.

Outpatient:

1) outpatient evaluations of drinking/substance abuse problems;
2) a primary outpatient program which provides an intensive treatment experience (4 times per week for one month, then once per week for ten weeks);
3) education and information groups for individuals

interested in learning more about alcoholism/substance abuse and individuals charged with driving while under the influence;
4) aftercare-support groups for patients being discharged from inpatient treatment;
5) a three day, off campus, Family Recovery Program aimed at meeting the needs of the spouse, other family members and friends; and
6) an independent living program (55 beds) which provides a temporary residential setting for patients to strengthen their recovery and re-establish relationships with significant others.

Outpatient services are provided at LCSA and at a southwest suburban facility in Countryside, Illinois.

In addition to the aforementioned independent living facility for adults, an aftercare residential facility for adolescents is available and operated by PMS.

LEVELS OF CARE

The levels of care available in this system of treatment are:

Level I

CRITICAL MEDICAL AND/OR PSYCHIATRIC CARE:
These services are provided at Lutheran General Hospital in an intensive care unit for medical/psychiatric problems. Closed and open psychiatric units and the emergency room services are also available.

Level II

ALCOHOLISM/SUBSTANCE ABUSE SPECIALTY HOSPITAL:
This facility treats concurrently medical/psyciatric problems associated with alcoholism and substance abuse. These patients have medical/psychiatric problems that need a hospital based treatment program.

Level III

RESIDENTIAL FREE-STANDING REHABILITATION FACILITY:
This program provides treatment for alcoholism/substance abuse without concurrent medical/psychiatric complications that require a hospital based treatment.

The basic difference between Levels II and III is extent and degree of medical/psychiatric impairment.

Level IV

ALTERNATIVE LIVING PROGRAMS:
These programs provide an opportunity for individuals to live in a structured, supportive environment while attempting to re-establish personal relationships, gain a period of sobriety and prepare to either return to

their previous living situation or to establish a new living situation.

Level V

OUTPATIENT SERVICES:
These programs run the gamut of one-time evaluations through intensive treatment programs for both individuals and families.

PROVIDERS

The professional staff who deliver the treatment services and provide the care to the patients represent the following professions: psychiatry, internal medicine, nursing, social work, counselors, pastoral care, recreational therapy and dietary.

PATIENT PROFILE

The framework of levels of care provides a system for matching patients' needs with treatment services. An array of treatment programs and services are available.

Descriptively our patients have the following characteristics: 70% are males; average age 39 years; 66% primarily abuse alcohol although 50% indicate misusing another substance besides or in addition to alcohol; and the overwhelming majority report experiencing the key symptoms of dependency (increased tolerance and/or withdrawal).

Approximately 2,100 inpatient admissions and 10,000 outpatient visits occur on a yearly basis.

About 70% of the patients live in Chicago or the northern suburbs. However, 20% come from either out of state or outside the Chicago metropolitan area.

DURATION OF TREATMENT

The overall average length of stay at LCSA is 14 days. This number varies depending on the specific treatment unit. For example, specialty care has a length of stay of 18 days.

At the time of discharge, in addition to self help group referrals, over 75% accept a referral for additional professional services.

PROGRAM EVALUATION AND RESEARCH

LCSA is actively engaged in a range of program evaluation and research activities. These activities represent the Center's commitment to understanding the processes associated with the disease of alcoholism and substance abuse as well as the effectiveness of specific programs and services to treat this disease.

Research into the etiology and recovery of alcoholism/substance abuse represents major undertakings of the Center.

In order to enhance the ability of the Center to engage in evaluation and research activities a clinical data base has developed as part of a new medical record. Thus, the medical record will act as the information document which will support many of these research and evaluation activities.

The quality of patient care is enhanced by this new medical record because it structures and organizes the data that are deemed vital to good patient care. Furthermore, these data are consistent across programs and for all patients.

QUALITY ASSURANCE, UTILIZATION REVIEW, MANAGEMENT INFORMATION REPORTS

LCSA's Quality Assurance Committee meets monthly. The QAC evaluates and monitors patient care, identifies problems and develops methods to correct problems.

The Utilization Review Committee examines the need for extended stays and randomly examines charts to establish the justification for admission and rationale for extending care.

Monthly management reports highlight the activities within the inpatient and outpatient programs. Such reports provide a monitoring of activities and services. Furthermore, they provide a data base upon which planning and development activities can proceed.

ScrippsMemorial
Hospital

LaJolla

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30 July 1982

TO: SENTATE SUB-COMMITTEE ON HEALTH: SPECIAL MEETING
TO CONSIDER MEDICARE PAYMENT FOR ALCOHOLISM TREATMENT

HONORABLE SIRS:

Having been unable to appear at your 17 July 1982 Hearing on the above, I am taking this means of bringing to your attention a particular view in support of Medicare payments for alcoholism treatment.

I am a Certified Alcoholism Counselor at the Scripps Memorial Hospitals/La Jolla, California, a recovering alcoholic and counselor for a special group of alcoholic patients called "Top Of The Hill." I am 65 years of age and six years into my program of sobriety.

An average of 35% of our patients here at Scripps Memorial Hospitals are 55 years of age and older. Of these, a significant number did not develop identifiable alcoholism until age 60 or above. Persons whose alcoholism manifests itself in this way are known as "late onset alcoholics," and generally present themselves for treatment at about Medicare eligible age. These are persons who, having suffered none of the usual devastation of family, career and health (and indeed having had no inkling that these developments were in store for them) are nevertheless every bit as worthy of proper treatment as those in any other age group.

Consider please the distinct possibility that "late onset alcoholism" could be the fate of some number of you who now sit in consideration of this whole issue! I urge strong consideration for the inclusion of Medicare payments for alcoholism treatment.

Sincerely,

Howard R Gwynn, Jr

Howard R. Gwynn, Jr., CAAC
Alcoholism Treatment Center

STATEMENT ON MEDICARE REIMBURSEMENT FOR ALCOHOLISM TREATMENT

BY EDWARD J. CARELS, PH.D.
VICE PRESIDENT/COMMUNICATIONS
COMPREHENSIVE CARE CORPORATION
NEWPORT BEACH, CALIFORNIA

Mr. Chairman:

While we understand Congress' need to reduce budget deficits and trim some $15.25 billion from the Medicare budget during the next three years, we question whether cutbacks or major revisions in Medicare reimbursement for alcoholism is prudent public policy. Since members of this subcommittee voiced concerns about "treatment of alcoholism in more expensive institutionalized settings," we assume that you will be exploring cost-cutting measures. Some questions we urge you to consider during this hearing are:

1) Are we as a nation spending too much money on alcoholism?

2) Compared with other diseases, is Medicare spending a disproportionate amount on alcoholism?

3) Is it appropriate to treat elderly alcoholics in a hospital?

4) What happens if Medicare pays for alcoholism treatment in a hospital at nursing home rates? Or reduces length of stay?

5) What problems exist with the Health Care Financing/National Institute on Alcohol Abuse and Alcoholism's study of alternative treatment programs?

6) If Medicare reimbursements must be reduced, why is one disease being singled out? And will this discrimination evoke lawsuits?

7) Is the adverse publicity on Raleigh Hills prejudicing this committee against all hospital treatment programs?

I am Dr. Edward J. Carels, vice president of communications for Comprehensive Care Corp., a nationwide health care management organization. We are the nation's largest private provider of treatment for alcohol and related drug problems, caring for some 40,000 patients annually in our hospitals and contract units -- CAREUNITS -- in community hospitals. In some of our contract units, particularly in Florida and California, about one-third to one-half of the patients are ages 65 and older. Most are on Medicare. Approximately 10 percent of the patients in our hospitals are covered by Medicare. Below, we offer our perspective on the questions we ask your subcommittee to consider.

1) ARE WE AS A NATION SPENDING TOO MUCH MONEY ON ALCOHOLISM?

When we discuss alcoholism and alcohol abuse, we are not talking about anxiety neurosis or an ill-defined health problem, we are talking about a progressive, life-threatening and devastating disease. Alcohol abuse and alcoholism cost this nation $79.6 billion in 1982 dollars, affect some 14 million people and their families, cause or contribute to some 25 other diseases and lead to 10 percent of all deaths in this nation. The average alcoholic dies 12 to 15 years earlier than the general population. Yet only 15 percent of alcoholics and problem drinkers receive formal treatment for their disease of alcoholism, and the 1980 National Drug and Alcoholism Treatment Utilization Survey reports that $940,572,000 (less than $1 billion) was expended for specific alcoholism treatment. Americans spend as much or more money on diet drinks, bikes, running shoes and bottled water than they do on alcoholism treatment. Americans spend a whopping $50.8 billion annually on beer, wine and spirits. Ironically, the beverage industry spends more money advertising alcohol products than the entire country spends treating the disease resulting from excessive consumption. In summary, the U.S. doesn't spend enough on this disease compared to its costs to society.

2) COMPARED WITH OTHER DISEASES, IS MEDICARE SPENDING A DISPROPORTIONATE AMOUNT ON ALCOHOLISM?

While alcoholism is on the list of 25 top diagnoses for Medicare, it is comparatively one of the least expensive treatments. In a 20 percent sample of Medicare inpatient discharges compiled by the Health Care Financing Administration, the cost per discharge of alcoholism treatment was $1,188.29. The cost for a heart attack was $2,699.91 and for heart disease with surgery, $4,968.35. (The chart is attached.)

Neither is Medicare reimbursement for alcoholism a substantial portion of the Medicare budget. In fiscal year 1979, the Medicare program paid about $100 million for the treatment of alcohol-based disorders and alcoholism, of which $90 million was for institutional care and the remainder for physicians' services. In fiscal year 1980, the Medicare budget was approximately $35 billion. Medicare payments for alcoholism treatment would be about .2 percent of the budget.

Untreated alcoholism will cost the Medicare substantially more than treatment. For example, alcoholism and alcohol abuse are associated with up to 68 percent of all cases of pancreatitis, up to 95 percent of cirrhosis-of-the-liver cases, up to 60 percent of nutritional deficiencies, up to 24.4 percent of all peptic ulcers, and about 3 percent of heart problems. Alcohol abuse is a significant factor in developing cancer of the tongue, mouth, esophagus, larynx and liver and in developing hypertension.

It is common sense to treat the primary disease of alcoholism -- rather than to wait for the even more severe medical resultants to surface particularly when alcoholism treatment and rehabilitation have been shown to be effective. Recovery rates (sustained abstention at 18-month follow-up) for socially stable alcoholics are approximately 60 percent or more. Our treatment teams who work with elderly alcoholics indicate that their prospects for recovery are as good or better than younger alcoholics. And recovered alcoholics reduce their utilization of medical and hospital services by a median of 40 percent.

3) IS IT APPROPRIATE TO TREAT ELDERLY ALCOHOLICS IN A HOSPITAL?

There are an estimated 3.5 million elderly alcoholics or problem drinkers in this country. The majority will die from their dependency on alcohol, because they are never identified or treated. Only 2 percent of the alcoholics in formalized treatment programs are elderly, according to the State Alcoholism Profile Information System's March 1982 report. The death certificates of the undetected elderly alcoholics may list cause of death as accidental, heart disease, cancer of the digestive tract, suicide, but the real cause will be alcoholism.

There is no one best treatment approach or setting for alcoholism treatment. A continuum of care must be provided. For some of our elderly patients with no family, we may refer them to a recovery home following treatment. Outpatients and residential programs unable to treat the medical complications of alcoholism often refer patients to our programs. An early-stage, relatively healthy alcoholic can be treated in less acute programs. Late stage and physically debilitated alcoholics need to be treated in hospital programs where competent medical care and life-saving equipment are immediately available. A note from a now recovering CAREUNIT patient attests to this need:

> "The most important fact to me concerning the CAREUNIT is that I would not be alive now had it not been for precise, immediate care, in that shortly after admission, I went into respiratory arrest. I am not really sure which nurses were actually in attendance at that moment, but I know that their swift, confident actions are responsible for my being successfully resuscitated... I owe them my life, because in that extreme moment, they worked and worked to not let me slip away."

The elderly alcoholic who enters our treatment program is generally in frail health. Medical problems prominent in the elderly include amnesia, convulsions, Korsakoff's psychosis, peripheral neuropathy, gastritis, anemia, cardiomyopathy, pancreatitis, liver disease and pneumonia. There is also a high level of poly-drug abuse among elderly alcoholics, who frequently combine alcohol with tranquilizers or prescription drugs. Because of these conditions, they require close medical attention during withdrawal and careful monitoring during the treatment phase. Alcoholism can kill people in a variety of ways.

Medicare regulations and the PSRO review system also work to insure that an elderly alcoholic admitted to a hospital-based program should really be there. Medicare's hospital insurance covers up to five days for detoxification, and up to 21 days of active treatment, including a detoxification and rehabilitation program. A Medicare patient may be readmitted one time for inpatient alcoholic rehabilitation, with a maximum coverage of 19 days. To admit a patient to a hospital program requires that:

a) A physician prescribes inpatient hospital care
b) The care can be provided only in a hospital
c) The hospital is approved for Medicare participation
d) The Professional Standards Review Organization does not disapprove the stay

Additionally, PSRO's have recently developed review criteria for inpatient alcoholism treatment with input from providers. The criteria are good and should substantially eliminate the prospect of inappropriate hospitalization for alcoholism. Lastly, no one treatment program is best suited for all patients. Not all patients need hospitalization. But some do.

4) WHAT HAPPENS IF MEDICARE PAYS FOR ALCOHOLISM TREATMENT IN A HOSPITAL AT NURSING HOME RATES? OR REDUCES LENGTH OF STAY?

Under the Medicare system, alcoholism treatment is reimbursed at 100 percent of costs considered to be reasonable and necessary. This figure translates to about 75 percent of the actual charges. Thus, the federal government is already receiving a discount. We are concerned that if alcoholism treatment payments are lowered to skilled nursing facility rates, there will be negative results, leading to a turning away of patients or cost shift. When cuts have been made in Medicare reimbursements, there has often been a shift of the cost to private-pay patients and third party insurers. It is questionable how much longer these groups will continue to absorb more than their fair share of the costs. Another unhappy prospect is that hospitals would balk at accepting Medicare patients who are alcoholics. This change could, in effect, hasten the death of many elderly alcoholics.

Arbitrary cutbacks in the length of stay for in-hospital treatment reimbursed by alcoholism may also be shortsighted. Many clinicians have indicated that a 30-day stay rather than the present 21 is medically advisable, because of the elderly patient's prolonged detoxification and slower recovery. During these times of budget austerity, we realize that it is unrealistic to propose an extension of the length of stay. But we warn that reductions of length of stay to detoxification only would lead to a revolving door of elderly alcoholics. It is very dangerous to practice medicine by regulation.

5) WHAT PROBLEMS EXIST WITH THE HEALTH CARE FINANCING/NATIONAL INSTITUTE OF ALCOHOL ABUSE AND ALCOHOLISM'S STUDY OF ALTERNATIVE TREATMENT PROGRAMS?

The Health Care Financing Administration and National Institute of Alcohol Abuse and Alcoholism are cooperating on a four-year-long project to study the feasibility and cost-effectiveness of providing Medicare and Medicaid in 110 nontraditional settings, such as outpatient facilities, halfway houses and residential programs. An estimated $32 million in Medicare and Medicaid funds will be used to reimburse these nontraditional programs during the test period. Preliminary evaluations will not be completed for another 18 months. We have several concerns with the study. First, it looks at feasibility, utilization and costs, but not treatment outcome. How can you disassociate them? If a treatment program is cheaper but does not produce satisfactory results, is it really worthwhile?

There is a second concern. Patricia Hirsch Feinstein, speaking at a workshop for grantees in the HCFA/NIAAA demonstration program, said that, generally, "when new services or new providers are covered under a program, their costs turn out to be add-ons rather than substitutes for existing services. We are hopeful that this will not be the case with this demonstration..." (The Alcoholism Report, Dec. 15, 1981.)

We suspect her concern is valid. Blue Cross/Blue Shield plans in North Carolina, Kansas and Maryland explored the efficacy of expanded non-hospital benefits as a cost-savings device, but found that the cost of additional outpatient benefits were not offset by savings from eliminated admissions. With the shift had come new providers eligible for payment and a tremendous increase in utilization of non-hospital services. We suggest you commission a GAO or OMB study of the true cost-effectiveness of such a shift. While we don't believe reimbursement for all non-hospital programs will save money, we do recognize their contribution to the alcoholism treatment continuum. A variety of treatment approaches is needed for the treatment of alcoholism as with any disease.

Third, there is no hospital in the study. It's hard to imagine how to demonstrate A is more cost-effective than B when B isn't included in the study.

The National Drug and Alcoholism Treatment Utilization Survey of September 1980 reports that hospitals cared for only 12.3 percent of all individuals being treated for alcoholism, whereas outpatient facilities were treating 71.3 percent, halfway houses and recovery homes, 6.2 percent, and other residential facilities, 7.7 percent. Most alcoholics are treated outside the hospital already.

6) IF MEDICARE REIMBURSEMENTS MUST BE REDUCED, WHY IS ONE DISEASE BEING SINGLED OUT? AND WILL THIS DISCRIMINATION EVOKE LAWSUITS?

The American Medical Association urges that coverage of medical care "not be made on a discriminatory basis based upon the nature of the illness." Alcoholism has been recognized by the AMA, the World Health Organization and others as a disease. It has been discriminated against long enough. Additionally, if reimbursement for alcoholism treatment in a hospital is severely cut back, we suspect that there will be legal repercussions. When the Office of Personnel Management recommended cutting mental health benefits, a number of psychiatric organizations and several individual federal employees joined in a suit against OPM.

7) IS THE ADVERSE PUBLICITY ON RALEIGH HILLS PREJUDICING THIS SUBCOMMITTEE AGAINST ALL HOSPITAL TREATMENT PROGRAMS?

Media coverage focusing on Raleigh Hills Hospitals has raised questions about inappropriate hospitalizations, high treatment costs, patient care deficiencies, and possible Medicare fraud. If there have been illegal acts, the investigations now being conducted by the inspector general of the U.S. Department of Health and Human Services, the FBI, as well as state and local health officials, will uncover them. We believe it is unfair to drastically alter Medicare reimbursement for one kind of treatment setting because of alleged misconduct of one provider. They are still innocent until proven guilty. Congressional hearings and reports by the U.S. General Accounting Office indicated that 10 to 25 percent of the Medicaid program involves fraud. We do not believe you'll find problems of this magnitude within the alcoholism field.

While we have raised these questions about Medicare reimbursement for alcoholism, and provided our perspective, we also recognize the budgetary limitations your subcommittee must work with. For that reason we recommend:

1) That the General Accounting Office project the cost savings achievable by reducing Medicare reimbursement for hospital treatment compared to the long-run cost expenditures of treating pancreatitis, cirrhosis and other medical complications which result from untreated alcoholism.

2) That any reductions in Medicare reimbursements be applied equally to all diseases, not just alcoholism.

3) That any prospective reimbursement plan be considered for all diseases, not just alcoholism.

Ignoring and slighting treatment for alcoholism in the elderly will not make the problem disappear. We question whether it is OK for elderly alcoholics to drink to the point where they suffer severe brain and heart damage which Medicare would pay for, but not for a treatment program which would address the cause of the brain and heart damage -- excessive drinking.

MEDICARE INPATIENT DISCHARGES
(20% sample of inpatient bills)

	TOTAL CHARGES IN SAMPLE	TOTAL DISCHARGES IN SAMPLE	PATIENT DAYS	COST PER DISCHARGE	COST PER DAY
Alcoholism	$ 14,677,711	12,352	87,784	$1,188.29	$167.20
Malignant neoplasms trachea, bronchus, lung	$ 27,612,516	16,934	145,020	$1,630.60	$189.35
Malignant neoplasms prostate with surgery	$ 38,967,066	17,809	177,812	$2,188.05	$219.15
Total-malignant neoplasms cited	$ 66,579,621	34,743	322,832	$1,916.35	$206.24
Acute myocardial infarction	$155,320,604	57,528	729,403	$2,699.91	$212.94
Chronic Ischemic Heart Disease	$293,931,310	196,271	1,541,698	$1,497.50	$190.65
Chronic Ischemic Heart Disease with surgery	$111,012,770	22,344	292,921	$4,968.35	$370.99
Ill-defined Heart Disease	$ 15,016,840	10,080	77,258	$1,489.77	$194.37
Other Acute and Subacute Forms of Ischemic Heart Disease	$ 25,205,865	14,774	116,353	$1,706.10	$216.63
Agina Pectoris	$ 700,758	569	3,582	$1,231.50	$195.63
Total-heart ailments	$601,188,147	301,566	2,761,215	$1,993.55	$217.72

Data from Medicare Provider Analysis and Review, compiled by Health Care Financing Administration, 1977-78 reports.

TREATING THE ELDERLY ALCOHOLIC

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ABSTRACT

Among the 25 million Americans age 65 and older, there are an estimated 2.5 to 3.7 million experiencing problems with alcohol. Alcoholism intensifies geriatric medical problems and a high proportion of these problem drinkers will be admitted to the acute medical wards of general hospitals. This article describes characteristics of elderly problem drinkers, delineates problems in identifying them, and discusses approaches to treating them used at three Careunits, short-term alcoholism treatment programs within general hospitals.

The diagnosis can be varied--cardiomyopathy, schizophrenia, Organic Brain Syndrome, but for many older persons, alcoholism is the hidden primary disease. One in five elderly patients receiving treatment for medical, surgical or psychiatric difficulties is an alcoholic or problem drinker.[1] Among the 25 million Americans age 65 and older, there are an estimated 2.5 to 3.7 millior addicted to alcohol.[2]

The U.S. Department of Health, Education and Welfare in its "Third Special Report to the U.S. Congress on Alcohol and Health," pointed out that "Diagnostic problems constitute perhaps the greatest barrier to treatment of alcoholism among senior citizens. What is perceived as frailty, senility or simply the unsteadiness of old age may in fact be alcoholism."[3]

Even when older alcoholics are identified, some question exists as to how receptive they are to treatment and where they should be treated.[4,5]

To provide some perspective on these issues, the experiences of treating elderly alcoholics at three CareUnits are described. The CareUnits are part of a nationwide network of inhospital treatment facilities. The three described in this article are located in areas with a substantial elderly population. Doctors Hospital of Sarasota is in Florida, the state with the highest percentage

continued

of elderly people, 18.1 percent, of any state in the nation. South Coast Medical Center in South Laguna is in California, a state with 2 million people 65 or older. Providence Hospital draws from an elderly population of 73,000 in the District of Columbia.[6]

Recent research and the clinical experience at the CareUnits show that advanced age is not a contraindication to treatment. With treatment directed at their needs, many elderly alcoholics recover. The prognosis is about the same as for younger alcoholics and may be somewhat better for those whose alcoholism developed late in life.[7,8]

Several methods have been suggested for treating the elderly alcoholic--outpatient, home visits, in a facility for the elderly, in a hospital and in an alcoholism treatment center.[9,10] The CareUnits provide a three- to four-week alcoholism treatment program within a community hospital, followed by 10 weeks of aftercare. The location of the CareUnits within community hospitals permits the treatment of alcoholism as well as other chronic conditions faced by older persons.

Patient Characteristics

Elderly alcoholics do not drink as much as younger alcoholics, but tend to drink daily. Their consumption declines with age. Researchers relate the decline to alterations in metabolism, body composition and brain sensitivity.[11,12]

There are several patterns of alcoholism among the elderly. Some have been addicted to alcohol for many years and managed to survive into old age. They have a high incidence of physiological problems related to brain, liver,

continued

pancreas and muscle damage. There are situational drinkers (late onset) who use alcohol to cope with the pressures and crises of old age. They may start drinking more because their spouse died and they are lonely, because they retired and feel devalued by society, or because they are ill and seek relief from the pain and discomfort. A minority are relapse drinkers. They recognized they had a drinking problem when they were young, abstained from alcohol for 30 to 40 years, and then relapsed as senior citizens.

Nearly 10 percent of the alcoholics treated in the CareUnit at Providence Hospital in Washington, D.C., are 65 years of age or older. Some are in their 80s. Many are retired government people who develop alcoholism late in life in response to a life crisis.

Approximately 40 percent of the patients at the CareUnit at Doctors Hospital of Sarasota are elderly. More than half of these did not begin drinking until their 60s and 70s. They drank socially at a young age, had a strong work ethic and worked hard all their lives. They came to Florida planning to live a life of leisure and enjoy the "Golden Years." It has not worked out. The cost of living is high. They worry about finances, their health and their children. They are bored. Many are lonely after the loss of a mate. Some living in condominiums get caught up in the condominium cocktail circuit. They start drinking at 2 or 3 in the afternoon every day.

At South Coast Medical Center's CareUnit, nearly one third of the alcoholics treated on the unit are 65 years of age or older. They come from nearby retirement communities. In these communities, they often start drinking early in the morning and rarely leave their homes. Liquor is delivered. Bulk liquor sales near one California retirement community are the highest in the state.[13]

continued

Identifying elderly alcoholics is difficult. They are less likely to get in trouble with the legal system than younger alcoholics; most no longer work, so employer pressure is non-existent; families cover for them; and health care providers often misdiagnose their problems.

Families of older alcoholics may do nothing to get help for several reasons. They may feel it is disrespectful to suggest the older relative has a problem with alcohol. They may feel shame and want no one to know about their relative's "weakness." They may believe the elderly person deserves whatever solace he or she can find in remaining years--even if it is alcohol. In other instances, the family may encourage the older person's excessive drinking, believing it makes him or her easier to handle. It is usually when the elderly person develops a serious illness or is injured or when a spouse becomes desperate that the family brings the alcoholic to the attention of the medical community.

Health care providers not sensitized to the problems of elderly alcoholics, frequently see physical and mental disorders as symptoms of aging rather than conditions aggravated or caused by alcoholism.[14] Alcohol greatly accentuates the problems of aging.[15] It intensifies memory loss, heart disease, emphysema and other disorders and exaggerates behavior. As a consequence of the aging process, the elderly generally tend to become more childlike, hostile, crotchety and impatient. Alcohol makes these moods worse. An older person may seem senile, but once the alcoholism is treated the symptoms clear up.

Other medical problems prominent in the elderly alcoholic include amnesia, deliriums, convulsions, Korsakoff's psychosis, peripheral neuropathy, gastritis,

continued

anemia, cardiomyopathy, pancreatitis, ulcers, liver disease, pneumonia and fractures and broken bones from falls.[16] Alcoholism exaggerates psychological problems--anxiety, depression and suicidal ideation. It can mimic schizophrenia.[17,18] Frequently, the elderly patient is admitted to a hospital under one of these diagnoses rather than alcoholism.

For help in identifying elderly alcoholics, CareUnit treatment teams turn to social workers at retirement communities or senior citizen centers, workers at nutrition sites for the elderly, family physicians, nurses, home health aides, and clergy. They alert these groups to look for clues of alcoholism in the elderly. These clues include self-neglect, injuries, depressive moods, anorexia, excessive incontinence, aggravation or confusion, paranoia, and the imbibing of more than two drinks in one day.[19,20] Physicians are encouraged to include questions about drinking in medical histories, and to question family members or friends of the elderly patient when drinking problems are suspected.

Intervention

Elderly alcoholics have difficulty admitting they have a drinking problem. Most do not believe they do. Even if they suspect a problem, few will say they are alcoholics. Their view of alcoholism emanates from the Prohibition period when someone who drank heavily was regarded as a degenerate or immoral person. However, an intervention, a loving confrontation to convince the elderly alcoholic patient that he or she is sick and needs help, has been used effectively in the CareUnits.[21] In an intervention, the family, friends,

continued

physician, family minister, and others close to the elderly alcoholic give specific details of how the alcoholic's personality has changed, and how his or her physical health has deteriorated. They describe how he or she refuses to pay bills, go to the doctor, work around the house or be civil to a spouse. At South Coast Medical Center's CareUnit, interventions have been accomplished with as few participants as one therapist, the alcoholic and one family member.

Therapeutic Program

The program at the CareUnits follows a medical model. Alcoholism is viewed as a primary, progressive yet treatable disease. Team treatment is used. Not only a physician but a social worker, alcoholism therapist, psychologist and specially trained nurses are involved in the care. Frequently, at least one member of the treatment team is a recovered alcoholic.

Once the elderly patient enters the CareUnit, he or she undergoes a series of medical and psychological examinations. If needed, a detoxification process is begun.

Detoxification

Detoxification, normally accomplished in two to three days, can take twice as long for an elderly alcoholic, depending on the the patient's physical condition. It may take a week or two for the person's head to clear, the memory to return and for the patient to become ambulatory.

continued

Once the physical problems are controlled, the elderly patient enters a comprehensive therapy program designed by the multidisciplinary team of professionals. The program includes lectures about alcoholism and life problems, films, workshops, daily sessions of group and individual counseling, family sessions, and recreation therapy.

The elderly patients are intermingled with adult alcoholic patients of all ages. Occasionally, there are problems in treating both elderly and young alcoholics in the same unit. But the problems can be overcome. At Doctors Hospital's CareUnit the treatment team has found the elderly need the stimulation of younger people. The younger people turn to the elderly patients for advice, making the older persons feel needed and wanted. At South Coast Medical Center's CareUnit, the elderly alcoholic patients leave the rest of the patients once a week and form their own group. There, they discuss such common concerns as living on a fixed income, having to move in with children and grieving over the death of family members and friends.

Despite the integration of ages, the treatment teams remain sensitive to their elderly patients' particular life problems and attitudes.

The elderly patients attend several information sessions about alcoholism and its effects. Their understanding of alcoholism is based on conceptions of two generations ago. They have not caught up with the newer ideas. Many discussions at the CareUnit focus on the disease concept of alcoholism to counteract the myths and stigma.

Many elderly patients combine alcohol with over-the-counter and prescription drugs. The treatment teams make them aware of the dangers of this practice. The elderly patients learn that many drugs lose their therapeutic value when

continued

combined with alcohol, while others can cause death. For example, alcohol combined with sleeping pills may cause severe depression of the central nervous system, even to the point of death. And alcohol when combined with insulin can make the control of diabetes more difficult.[22]

The relationship between aging and drug sensitivity is discussed to help make elderly patients aware of how they can slip from social drinking into alcoholism.

With this education about alcoholism and its long-term effects, the elderly patients begin to realize that any damage to their bodies by alcohol compromises the time they have left to live. That awareness gives them an incentive to stay sober.

The elderly patients also receive help in coping with marital stress and too much leisure time. While elderly patients may have viewed their retirement from work as an opportunity for a second honeymoon, that is often an unrealistic perception. The wife may not be used to having the husband underfoot. The emotional stress may be severe if the husband is drinking heavily as well. In some couples, personality conflicts submerged during the working years come to the surface. To help ease these tensions, classes are offered in communication skills.

Through recreational therapy and socialization programs, the staffs help the elderly patients find ways to relieve boredom and loneliness. Some of the elderly patients have worked all their lives, never developed a hobby or sports activity and do not know what to do with themselves. Others have moved and feel isolated from friends and family. Still others have difficulty with being alone after their spouse of many years dies.

continued

In working with the elderly, the CareUnit treatment teams emphasize the quality of life rather than quantity. To talk about a lifetime of sobriety to an elderly alcoholic is ineffective. They know they have only a few years left. The treatment teams emphasize making the best of those years.

Knowing that the family can influence the older person's willingness to remain in treatment, rate of progress and potential for sobriety, the CareUnit treatment teams seek to involve family members in the treatment program. The family unit contacted may include spouses, brothers and sisters, children, and even grandchildren. Weekly family seminars bring the alcoholic patients and their families together to discuss mutual concerns.

Aftercare

During the hospital stay, the elderly alcoholic patient learns how to cope with problems of living and to live a comfortable life free of alcohol. But particularly for the elderly patient, adequate aftercare and followup is a critical part of treatment.

For 10 weeks following the inhospital stay, the elderly alcoholic returns to the CareUnits once or twice a week for a group therapy sessions with other recovering alcoholics and for meetings with family members.

The lifelong alcoholic usually needs placement in an extended care facility. Treatment team members work with social workers and managers at those facilities to insure there is continuing support for the recovering alcoholic and that the elderly alcoholic is not pressured to participate in "afternoon martini time."

continued

For the life crisis drinkers, the teams work to get them involved in community and family activities. The support of family members who live with the recovering alcoholic or nearby is enlisted. Family members can help the recovering alcoholic find new outlets and provide emotional support during the readjustment period.

Getting the elderly involved in self-help groups, such as Alcoholics Anonymous, and in community activities is not always easy. Often they do not have transportation, are afraid to go out at night or do not want to leave a spouse alone at home. At Doctors Hospital's CareUnit, the CareUnit alumni help out. If necessary, they will drive an elderly recovering alcoholic to an AA meeting or see that the spouse is cared for.

Providing the elderly alcoholic with an effective treatment program requires a therapeutic environment, an expertise in alcoholism, a sensitivity to the aging process and life changes an elderly person undergoes, and an optimism that elderly alcoholic patients can recover. A majority of the elderly patients treated at the three CareUnits have achieved sobriety and found new richness in their remaining years. They have renewed relationships with family members, regained self-respect and found too much in life, as one patient said, "to sit around and pine away."

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PROGRESSION OF LATE ONSET ALCOHOLISM

AGE		USE OF ALCOHOL	FEELINGS
Early 60s	Last years of working	Social drinking	Can't wait for retirement
62-65 years	Retires. Stops working. May move. (LOSS)	Unrestrained drinking	Initial high.
66-68 years	Unstructured life. Unlimited time. Too little to do. Aware of aging. Tolerance for alcohol. Feels useless. (LOSS)	Begins to live to drink.	Bored. Disillusioned. Doubts self-worth.
68-70 years	Husband/wife dies. Friends start to die off. Physical problems increase. Financial worry on fixed income. Afraid of illness, surgery, and hospitals. (LOSS)	Begins to drink to live.	Depressed. Lonely. Begins to take death seriously.
70 years +	More financial worry. Stops driving. Activities become limited. Longer illnesses and less money to pay for them. Childern may relocate. Feels a lack of meaning left to life. Starts to question the value of life itself. (LOSS)	Begins to drink to die.	Afraid. Alone. Hopeless. Would be better off dead, and may give up.
	Unable to find pleasure or satisfaction in any area of life.		

Developed by:
Susan Mardon, L.C.S.W.
Comprehensive Care Corporation

RECOVERY FOR THE OLDER ALCOHOLIC

Develops spiritual self.	
Accepts life as it comes along.	Feels peace.
Works through losses that occurred during the drinking years.	Feels acceptance and relief. Likes self.
Starts to give. Doing for others who need help.	Learns he/she does not have to keep formal office hours to be useful.
Gets involved with people to fill the void left by alcohol.	Discovers he/she is not alone. Does not have to be lonely.
Chooses to live. Accepts help from others.	Gains hope for self. Loses negativity.

AGE STOPS DRINKING
(70)

FEELINGS

AUTHORS' BIOGRAPHIES

Forrest Chapman, M.D. -- Dr. Chapman is the medical director of the CareUnit Program at Doctors Hospital of Sarasota in Florida. Formerly, he was chief of staff at the hospital. In addition to being on the staff of Doctors Hospital and Sarasota Memorial Hospital, Dr. Chapman maintains a private practice as a general practitioner. He received his doctor of medicine degree from the University of Miami.

James Foster, M.D. -- Dr. Foster has been the medical director of the CareUnit Program at Providence Hospital in Washington, D.C., since 1978. He is a Board Certified internist and a Fellow of the American College of Physicians. He also maintains a private practice in internal medicine and works extensively with geriatric patients. He received his doctor of medicine degree from Georgetown University School of Medicine where he is now an association clinical professor of medicine.

Susan Mardon, L.C.S.W. -- Ms. Mardon is the program manager for the CareUnit Program and StressCenter Program at South Coast Medical Center in South Laguna, California. She has been involved in research on alcoholism and aging for the last four years. She was graduated from San Diego State University, and in 1976, became a licensed clinical social worker. She has been a social worker, alcoholism therapist and counselor in private practice. Presently, she is on the faculty of Saddleback Community College and is a guest lecturer at the University of California at Irvine.

STATEMENT OF JAMES FOSTER, M.D.
MEDICAL DIRECTOR
PROVIDENCE HOSPITAL CAREUNIT
ON MEDICARE REIMBURSEMENT FOR ALCOHOLISM

Mr. Chairman:

Thank you for this opportunity to appear before your subcommittee and offer my perspective as a physician on the particular problems of the elderly alcoholic and the appropriateness of in-hospital care.

I am Dr. James Foster, medical director of the CAREUNIT Program, an alcoholism program at Providence Hospital here in Washington, and assistant medical director of the Carmelite Order Home for the Aged and Infirm. I am a primary care physician certified in internal medicine and a Fellow of the American College of Physicians.

Approximately 200 patients treated in our CAREUNIT Program were 65 or older, and many were on Medicare. We have also treated several retired government workers. About half of the elderly alcoholics we treated have been drinking since their mid-thirties or forties. The remainder were "late-onset" alcoholics, who developed alcoholism in their sixties and seventies, following retirement or other major life changes.

Most elderly alcoholics are in extremely poor health, their bodies debilitated by years of continuous drinking or by the combination of the aging process and alcohol abuse. Even the "late-onset" alcoholic deteriorates much faster than a middle-aged alcoholic would. The transition from early to late-stage alcoholism can be a few years.

In the elderly, the complications and physical effects of alcoholism constitute a medical necessity which nearly always require in-hospital care preliminary to any meaningful participation in a recovery program.

Because of greater alcohol toxicity, detoxification in the elderly can take twice as long as it would for a middle-aged alcoholic. It may take a week before the patient's memory returns and he or she becomes ambulatory. The dangers of convulsions and severe medical consequences during detoxification are greater with the elderly alcoholic.

Alcoholism aggravates the problems of aging, particularly hypertension, heart disease and diabetes. It also causes such medical problems as malnutrition, liver disease, pancreatitis, peptic ulcers, skin diseases and eye disorders. Further, alcoholism induces depression and Organic Brain Syndrome. Unless the elderly alcoholic is detected and treated for alcoholism, he or she will repeatedly present the doctor's office, emergency room or hospital with alcohol-related problems.

I would warn that it is often inappropriate and ineffective to treat the elderly alcoholic in an outpatient or residential setting. In the Washington, D.C., area, many of the community alcoholic clinics and residential programs refer elderly alcoholics to our CAREUNIT because they are unable to handle them. They often cannot treat the accompanying severe medical problems of the elderly alcoholic or cannot provide a controlled environment to break the cycle of alcoholism.

An in-hospital program, in addition to providing competent medical care and life-saving equipment, provides an opportunity to remove the elderly alcoholic from the alcohol-associated environment and participate in a comprehensive and intensive therapy program. This has a very beneficial psychosocial effect. It provides the patient and the loved ones with an opportunity of new beginnings.

At our CAREUNIT, we have a multidisiplinary team of professionals who work with the patients to develop individualized treatment and recovery programs. The therapy program includes lectures about alcoholism and life problems, individual counseling, group therapy, family sessions, and introduction to self-help groups. Following the inpatient program, tnere is a formal aftercare period of 10 weeks where there are weekly group therapy sessions. Thereafter, the recovering alcoholic can return to an aftercare therapy session at any time if he or she feels the need.

The recovery prospects for our elderly alcoholic patients are as good or better than for our younger patients. The relapse rate of our recovering alcoholic elderly patients is less than that of the younger ones. Elderly recovering alcoholics appreciate the changes that have occurred in their health and life and want to enjoy the time they have left. Once free of their alcohol dependency, the elderly patients gain weight, their depression lifts, their alcohol-induced Organic Brain Syndrome disappears, and their hypertension, diabetes, and other medical conditions are more manageable and easier to treat.

[illegible]

8/13/82

The A Center

2000 Domanik Drive Racine, Wisconsin 53404
414-632-6141

The Rev. E. W. Belter D.D., President and Executive Director

July 23, 1982

The Hon. David F. Durenberger
353 RSOB
Washington, D.C. 20510

Dear Senator Durenberger:

I ask that the following statement be a record of a hearing of the Senate Finance Committee's Subcommittee on Health July 27 regarding Medicare coverage for the treatment of alcoholism.

I've been involved with alcoholics for over 20 years and have been president and executive director of the A-Center, an alcohol/drug treatment hospital in Racine, Wisconsin, since 1969. The A-Center was the first accredited alcohol/drug treatment facility in the world under JCAH. We were one of the first to combine the treatment of alcohol and other drug abuse in one facility, offering services to adults and adolescents, men and women. We were one of the first to be certified for Medicare and Medicaid payments among our peers. I've also been involved, through the Alcohol and Drug Problems Association of North America, with testimony regarding alcohol and other drug treatment coverage in national health insurance since 1972 and with inclusion under Medicare and Medicaid since 1978. I've been involved with securing insurance coverage for alcohol and drug abuse treatment in Wisconsin since 1969.

I would ask the following points be made a matter of record:

1. In consideration of Medicare coverage for the treatment of alcoholism, it would be most unrealistic not to also include drug addiction. Increasing numbers of those with a primary diagnosis of alcohol abuse or alcoholism also have a diagnosis of other drug abuse or addiction. Alcohol is the most dangerous and devastating drug in this country today.

2. You are correct in your reported statement that at least 15% of the elderly are believed to have alcohol and other drug abuse problems. The reasons range widely, all the way from increased socializing and entertaining at the time of retirement to the boredom, a sense of uselessness, loss of friends who have been dying one by one, inability to continue past recreation and hobbies, loneliness, etc. The cause is of import, but the result of abuse and addiction to alcohol and other drugs is an entity that must be treated of itself.

The A-Center is a J.C.A.H. accredited hospital providing inpatient and outpatient treatment services for alcoholism and other drug abuse

3. Since alcohol and other drug abuse is a debilitating disease, it must be treated or the abuser/addict will die. When treated, the alcohol/drug abuser has a better than two to one chance of recovery.

4. Because elderly persons do not have the stamina and resilence of their youth, medical intervention and care is essential. It will probably take longer than necessary for a younger person. Alcohol detoxification may take five to six days rather than the two or three days sufficient for younger persons. Detoxification from other drugs may take up to 14 days for the same obvious reasons.

   Treatment must go far beyond mere medical detoxification and immediate medical care. Imperative is the restoration of a person's sense of usefulness, discovery/rediscovery of how they can still be "contributors" rather than "relics on the shelf", reaffirmation of family relationships, (including the family's education and treatment regarding their opportunities to be supportive of their parent or grandparent). Also essential is the reaffirmation of spiritual and religious faith. All these aspects require interdisciplinary skills beyond that of the physician and the controlled environment of intermediate level inpatient treatment. It also requires the family's involvement on an outpatient basis. It requires outpatient follow-up support for 4-12 months after the inpatient treatment.

5. Statistics from the Alcohol, Drug Abuse, Mental Health Administration published in the December, 1979 supplement to "Medical Care" is an article titled "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization" clearly indicates that the treatment of alcohol and other drug abuse will save money. It reduces greater-than-normal other medical costs. Medicare (and Medicaid) coverage for alcohol and other drug abuse treatment is an investment in health that pays better than three to one dividends; where else can an investment give that return?

   Hopefully, there is no doubt that coverage of alcohol and other drug abuse treatment is morally and fiscally sound. I am of the firm conviction that that's not the arguable point.

6. Coverage under Medicare and Medicaid is the greatest opportunity for the federal government to give visible commitment to the treatment and restoration of alcohol and other drug abuers to productive living. Without such coverage, the federal government is proclaiming abandonment of these people to increasing illness, radically increasing costs for other medical complications, and death.

7. The real issue in your consideration is the control of coverage and thus, of cost. Recent allegations of excessively expensive alcohol/drug treatment by a for-profit chain should not be extended to all of us involved in the alcohol/drug treatment field.

   There are some general hospitals that have good alcohol/drug treatment programs. There are also some general and psychiatric hospitals that charge far too much and give little actual treatment except detoxification. These latter hospitals are blatantly filling otherwise empty beds to maintain their cashflow.

Recognition, certification and utilization of free-standing alcohol/drug treatment facilities, some licensed as special hospitals and some otherwise certified, could result in excellent treatment at substantially reduced costs. The preoccupation with medical care sometimes causes us to overlook the fact that there are allied health services that impact the patient more than direct medical attention. This is especially true in alcohol and other drug abuse treatment. Preoccupation with licensed general or psychiatric hospitals sometimes blurs the existence of free-standing alcohol/drug treatment facilities who offer better care at lower cost with greater success.

8. Accreditation of alcohol/drug treatment services under the Joint Commission on Accreditation of Hospitals is now shifting to an expensive and superficial medical model. They are abandoning specific criteria for accreditation of alcohol/drug treatment services and lumping it into a general hospital manual. This was lobbying through the JCAH by general acute hospitals and physicians. It will reduce required services and increase costs. Since Medicare used JCAH accreditation as a basis for certification, this should be an area of grave concern to you.

There are several of us who have been involved with both Issues 7 and 8, who would be willing to pursue this further with you, your staff and the Health Care Finance Administration. We ask time to pursue details of this in the immediate future.

Sincerely,

E. W. Belter

The Rev. E.W. Belter, D.D.

EWB:nn
enc.

MEDICAL CARE
December 1979, Vol. XVII, No. 12, Supplement

Section 2

Findings

Nature and Magnitude of the Impact

A REDUCTION in medical care utilization subsequent to ADM treatment does appear to occur under certain circumstances. However, that reduction needs to be discussed according to the general type of therapy that preceded it.

Alcoholism Studies

While all twelve of the alcoholism studies found a reduction in medical care utilization or expenditures, five of the studies used only surrogate measures of reduced medical care utilization such as reductions in sick days or reductions in sickness and accident benefits paid. (The summaries of these and all the other studies are located in the appendix. Page references are given in the Table of Contents.)

The magnitude of the reductions in medical care utilization, sick days or sickness and accident benefits paid was very substantial in all twelve of the studies. The reductions ranged from 26 per cent[21] to 69 per cent[22] with a median of 40 per cent. The number of sick days fell anywhere from 38 per cent[15] to 47 per cent,[16] and the amount of sickness and accident benefit reductions ranged from 33 per cent[17] to 48 per cent.[20] The Philadelphia Police[15] and Fire Department[16] studies estimated that savings of $1.10 and $.45 respectively were generated from reduced sick leave costs for every $1.00 spent on alcoholism treatment. The drop in medical care utilization was variously measured: 69 per cent fewer hospital days;[22] 40 per cent fewer outpatient visits;[24] reductions in inpatient and outpatient expenditures of 48 per cent,[18] 38 per cent,[23] and 27 per cent;[25] $.41 savings in general health care expenditures for every $1.00 spent on alcoholism treatment;[21] and total estimated health care savings of more than $1,000 per client.[19]

Methodological problems were present to varying degrees in all twelve of the alcoholism studies. Seven studies used time spans of one year or less before and after treatment. Four had study groups of fewer than 100 persons. Problems with comparison groups were considerable and are discussed in the section entitled "Cause of the Impact." Several other methodological problems are examined in the individual study reviews.

Drug Abuse Studies

While it seems plausible that rehabilitation of drug abusers would greatly reduce their medical care utilization, there is a dearth of literature on the subject. Two of the alcoholism studies did look at the drug abuse programs at their plants. Approximately 15 per cent of the Oldsmobile[17] study group were drug abusers. However, no attempt was made to determine whether the 33 per cent decline in sickness and accident benefits by the entire group was representative of the drug abusers as a subgroup. The Illinois Bell study[14] made a preliminary review of their drug rehabilitation program. It found that the drug program had the same 72 per cent job rehabilitation rate as did their alcoholism program. This preliminary review also speculated that, had it been more complete, the results of other measures would have been just as dramatic as those of the alcoholism program. However, no data were presented on such measures as the decline in sickness disability cases for those in the drug rehabilitation program.

In addition, two other studies at least indirectly touched upon medical care utilization. The St. Luke's Hospital study[28] found that 81 heroin addicts had 37 inpatient episodes averaging 20.6 days each for detoxification or other narcotic-related illness in the year before beginning methadone maintenance and no such episodes in the year after. The Guadenzia House study[29] used the Cornell Medical Index to determine that a therapeutic community improved 32 persons' perception of their own health by more than 40 per cent. Presumably, this would have correlated with less medical care utilization.

Mental Health Studies

Twelve of the thirteen mental health studies did show at least some reduction in medical care utilization following a mental health intervention. The reductions in medical care utilization ranged from five per cent for outpatient physician visits[11] to 85 per cent for hospital days.[1] The median reduction was 20 per cent. The one exception was the Mexican-American study.[9] Since this study involved a new neighborhood health center in a medically underserved community, the natural expectation is that the utilization of all services would increase in response to previously unmet needs.

Most of the studies covered a period of only one year before and after psychotherapy and found reductions in medical care utilization that tended to be moderate. There were three major exceptions. The West German study[1] found an 85 per cent reduction in average hospital days per year for the five-year period after mental health treatment. However, the initial level of utilization was not that of the study group, but rather that of a similar group from another author's study. The Kaiser-Permanente study[2a] found reductions of 62 per cent in outpatient medical visits and 68 per cent in hospital days by the fifth year after psychotherapy. However, those figures were 21 per cent and 52 per cent for the first year after. The Blue Cross of Western Pennsylvania study[7] found a medical-surgical expenditure reduction of 57 per cent when the period of approximately two years after psychotherapy was compared with a similar period before. One-year figures were not presented. The above figures from the three studies with the longest time spans suggest an hypothesis that the reduction in medical care utilization increases as the time after psychotherapy increases. Future research may provide the answer.

Three studies estimated the net cost of the psychotherapy provided. The Blue Cross of Western Pennsylvania study[7] found that the savings from reduced medical-surgical care were 133 per cent of the cost of the psychiatric treatment provided. The Four Settings study[10] found that the cost of the mental health care provided was offset by 4 per cent, 6 per cent, 61 per cent and 67 per cent from lower rates of outpatient medical care utilization in the four settings when the patients treated by mental health staff were compared with those who had a mental illness diagnosis but who were treated only by nonpsychiatric staff. The Kaiser-Permanente study[2c] devised a cost-therapeutic–effectiveness ratio by dividing medical care utilization from the year before psychotherapy by the sum of

FOR THE RECORD

THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.
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MARY E. ACKER, *President*
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August 3, 1982

Senator Dave Durenberger
Senate Finance Committee
Subcommittee on Health
2227 Dirksen Senate Office Bldg.
Washington, D. C. 20510

Dear Senator Durenberger:

The National Federation of Licensed Practical Nurses is pleased to offer its comments on alcohol treatment coverage under Medicare. Our organization is the professional association of the 650,000 licensed practical nurses in the United States.

We have a particular interest in this area because many LPN's work in various settings throughout the United States treating individuals who suffer from alcoholism. Unitl recently, alcoholism was not acknowledged as an illness and even now, many will not accept it as such. It is not surprising, under these circumstances, that rehabilitation programs have neither been properly funded nor adequately developed. The time has come, however, to put the misconceptions of the past behind us and bring treatment of this disease into modern perspective. We must realize that not only does alcoholism pose tragic consequences for those directly involved, it also places a substantial fiscal burden on society as a whole. To combat these problems we are looking for alternatives which will provide cost-efficient and appropriate care for those suffering from alcoholism and alcohol-related disorders.

The American Hospital Association has estimated that "approximately one-half of all occupied beds in the United States are filled by people with ailments linked to the consumption of alcohol." This illustrates the severity of the alcohol problem in this country. We must realize that detoxification is not a cure for alcoholism; it is simply an initial step in rehabilitation. Alcoholism is a progressive disease which curtails productivity and is the primary cause of many medically related disorders such as cirrhosis and gastrointestinal bleeding. If alcoholism remains untreated, it usually results in death. The alcoholic may, however, live for 30 years with this condition, incurring substantial medical costs and

NFLPN: The Professional Organization for Licensed Practical/Vocational Nurses in the United States

serving as an unproductive burden on society. It is clear that providing appropriate care for these individuals is not only the proper thing to do, it is also the most cost-effective.

Recently, there have been new developments in the treatment of alcoholism. It has been recognized that not all rehabilitation must take place in a hospital setting. Free standing alcoholism rehabilitation facilities and out-patient care may well prove to be quite beneficial as well as cost-effective. Aside from the acute stages of alcoholism, in-hospital treatment, which is by far the most expensive type of care, may be unnecessary. Unfortunately, at the present time, no other type of care is covered by the Medicare program.

As health care providers, we would like to see the choices for the treatment of alcoholism expanded to provide for the varied needs of patients. We feel that we can serve as a vital part of the rehabilitation process in a variety of facilities by providing counseling, education, and follow-up care. Instead of trying to determine whether in-hospital or out-of-hospital programs provide the best care in general, we should direct our efforts towards insuring that the "appropriate" care facilities are available to meet the varied needs of our patients.

We would urge that the present Medicare coverage be extended to include free-standing alcoholism treatment centers which provide 24-hour residential care. This is significantly less costly that in-hospital care. We would also recommend that Medicare benefits cover other out-patient facilities which are deemed safe and effective. These measures we believe will provide a much more enlightened, as well as a cost-effective way, of dealing with rehabilitation.

Our primary concern is with providing treatment which will appropriately fit the needs of our patients, while proving to be cost-effective. We would, however, like to stress that failure to properly rehabilitate those suffering from alcoholism will inevitably result in a cost far greater than any treatment programs we would hope to implement.

As the nation's second largest group of health providers, licensed practical nurses are extremely concerned about the appropriate treatment of alcoholism. We hope this committee will continue its efforts to seek ways to provide health care delivery to those in need.

Sincerely,

Mrs Mary Acker

Mrs. Mary Acker LPN
President

MA/pdv

AHS
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July 27, 1982

The Honorable David Durenberger
Chairman
Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Re: Hearing on Medicare Coverage of Alcoholism Treatment

Dear Mr. Chairman:

On behalf of Raleigh Hills Hospitals, the owner or operator of 22 alcoholism treatment hospitals and five outpatient programs, I would like to express our appreciation for this opportunity to express to you our thoughts about alcoholism treatment coverage under the Medicare program. I am enclosing as my introduction to you my curriculum vita.

The history of alcoholism is in some ways more similar to the history of the civil rights movement than to the history of medicine. In both cases, a great deal of private and public denial have been prevalent for many long years. For both of these there continues to be denial and discrimination despite great strides in understanding and increased knowledge.

Alcoholism has only recently been accepted as a disease. Despite this acceptance, there are many who still believe that it is a moral and ethical issue requiring only a conscious effort by the victim in order to stop drinking. This attitude is broadly based in our society in which most people who drink are fortunately not facing the fate of falling victim to alcoholism and its many consequences. Alcoholism has often been labeled by

HEALTH SERVICES
- Raleigh Hills Hospitals
- Professional Practices
- Advanced Health Centers

MANAGED FACILITIES
- Inpatient Services
- Outpatient Services
- Specialized Services

HEALTH CARE TECHNOLOGY
- Management Services
- Technical Services
- Ancillary Services

the National Council on Alcoholism and others as the number one public health problem in the nation. The death rate in this country from alcoholism and its sequelae including auto deaths and suicide is thought to rank behind heart disease and cancer only. Despite these facts, the continuing denial can be diagnosed by a variety of symptoms.

For many long years other leading causes of death in our society have been made of prime interest to the National Institutes of Health. These illnesses have been made highly visible to the public and to the scientific community through the existence of discrete Institutes dedicated to the understanding, and to the ultimate cure, of diseases such as heart disease and cancer. These fine programs have been financially supported in their efforts by the Congress for many years.

For alcoholism, however, it was not until the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 that a similar Institute was established for alcoholism. Under the United States Code, Title 42, Section 4551, the National Institute of Alcohol Abuse and Alcoholism (NIAAA) was established within the Alcohol, Drug Abuse and Mental Health Administration. At no time since its establishment has that Institute's funding correlated proportionally with its significance as a health problem.

Just as gaining visibility for alcoholism in the Federal health research community has been a struggle, so too has gaining acceptance of the critical need to treat the disease as any other potentially fatal illness. It must be restated that we are considering a leading cause of deaths in this country. It is only recently that workers, both medical and non-medical, in the alcoholism field have succeeded in winning for alcoholics admission to general hospitals. For many years a primary diagnosis of alcoholism immediately excluded an individual from being a "proper admission" to a general hospital. So, instead of being admitted for alcoholism, they were admitted with another diagnosis, treated symptomatically and discharged only to be admitted again because the basic illness had not been attended to.

Gradually, over the years great progress has been made in correcting some of these fatal injustices. The Federal Government was foresighted in 1976 when Medicare issued Coverage Guideline 35-22 concerning inpatient hospital care of the alcoholic (although Medicare did allow inpatient alcoholism treatment before that). Similarly, over the years we have seen an increasing number of private insurers following suit and covering the care of this illness. These private insurers, like Medicare today, generally emphasize inpatient hospital care. We believe all insurers should expand their coverage to include other medically supervised settings, including outpatient.

The foresight of the Medicare program is now more clear than ever since we are becoming more and more aware of the magnitude of the alcoholism problem in older Americans (1). The lives of many older alcoholics have certainly been saved because of the access to alcoholism treatment made possible by the Medicare program. It would doubtlessly prove not only costly but fatal to this increasing older population if this benefit were reduced or eliminated.

Clearly, alcoholism and alcoholics had a late start in relationship to the attention given to other diseases by the medical/scientific community. It has not been possible in the last 12 years since the establishment of the NIAAA to answer all of the questions which need to be answered about the cause, treatment, and prevention of alcoholism. It should be pointed out that with the benefit of much more time, personnel, and resources, there are still unanswered questions about cancer and heart disease. One question, however, that is not asked about heart disease and cancer is, "Should we provide them with the treatment they need as best as we understand how to deliver that care?" It is unthinkable that anyone dealing with these diseases, that are, just as in alcoholism, chronic, relapsing, and at times fatal, would ask about when to stop trying. It is impossible to imagine someone saying that people with advanced cancer should be denied hospitalization because they have already been hospitalized once before for cancer. One can hardly imagine that someone who is having his third attack of heart failure would be told that he cannot be admitted to the hospital again because he failed to take the medicine that could have prevented the episode. Arbitrary denial of admission, however, seems quite possible to imagine when we are thinking about the chronic, progressive and ultimately fatal disease of alcoholism. The recently released guidelines from the National PSRO Council make substantial progress in assuring that proper criteria and medical necessity influence admission decisions. These critieria, we believe, are a very positive development; we applaud their issuance and welcome their implementation.

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(1) Brody, J.: Aging and Alcohol Abuse. Jnl of Am. Geriatric Society 30:123-126, 1982.

In the treatment of this disease, in which research has virtually just begun, there are considerations afield, not only limiting the number of times a patient may be ill, but also limiting the physicians' choice on where, in their best clinical judgment, the individual patient may be treated. Instead of asking the questions whether research can help us understand what treatments work best with whom, we are beginning to hear the question, should alcoholics be treated as inpatients or outpatients? Instead of asking the treatment community to make available a broad spectrum of treatments to suit individual needs, the danger is that there will be arbitrary limits imposed on the types and frequency of treatment before enough information is available to evaluate the results. We stand the chance of being asked to prove efficacy before we completely develop all of the possibilities. We seem to be witnessing a request for the magic, effective approach for a disease as complex as alcoholism when no similar requests are forthcoming for other equally complex diseases.

Policy may be made before good data exists. The result will be that not only will the data never come, but people will be harmed in the process. Much of this is done honestly in an attempt to control costs of health care. Would anyone be willing to consider similar proposals to control the cost of cancer care, heart care, and the like. If there are such restrictions on heart or cancer patients, then it is equitable for alcoholic patients. If not, then the stigma that alcoholism still carries must be operative. Hopefully, decisions of national policy are not made by attending to stigma and not logic.

The number of alcoholics in this country over 65 has been variably estimated to be between two and ten percent (2). One study on a special nursing home population revealed 20% (3). The aging population of the United States is a growing proportion of the total population (4, 5). The Federal Government has shown, with the passage of the Medicare program, an enlightened concern and leadership in helping the older American. It is hoped that this leadership will be continued and that coverage for the care of the alcoholic based on medical necessity and appropriateness of setting will be the response of the Congress to this growing national health problem.

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(2) Schuckit, M.D. and Pastor, P.A., Jr.: The elderly as a unique population: Alcoholism. Alcoholism: Clin. and Exp. Res 2:31-38, 1978.
(3) Graux, P.: Alcoholism of the Elderly. Rev. Alcohol 15:61-63,1969.
(4) Brody, op. cit.
(5) The Book of Numbers, compiled by the Editors of Heron House, 1978, pp. 9 & 51.

It should be stressed, however, that all settings and methods of care are not equal; nor are all providers equal. As in all fields there are experts and there are generalists, and there is likely to be a clear cost differential. We must be careful to avoid the creation of a system, whether under the Medicare program or otherwise, that allows only those who can afford it greater access to the higher quality which may be more expensive. This is not to say that high cost equals high quality by definition, but that relationship is not unusual in many fields and also is found in medical care.

It is hoped that positive interest in evaluation research can be taken realizing the great difficulty involved in this endeavor. We at Raleigh Hills Hospitals, in cooperation with Dr. Barry Tuchfeld of Texas Christian University, have undertaken what may well develop into the largest evaluation study of inpatient and outpatient alcoholism care ever done. This endeavor will, hopefully, allow us to begin to answer the question of what treatment is best for whom. Although we have no illusions that this research will definitively answer all of the questions in this extremely complex field, it will surely be a strong beginning. We would hope that similar evaluation programs could be undertaken by other providers, both public and private. By combining the energies and resources of many different and differing providers, rather than waiting for the single perfect controlled study, we may begin to get the kinds of data that will help us advance in our selection of the right treatment for the right patient in a prospective and not a retrospective manner. Perhaps the need for Federal leadership is in the positive direction of encouraging such evaluation and not in the premature restriction of options for older alcoholic Americans.

Again, I would like to express our appreciation for the opportunity to share with you and the other distinguished Members of your Subcommittee our thoughts on alcoholism treatment coverage under the Medicare program.

In closing, I respectfully request that this statement be included in the official permanent record of these proceedings.

Respectfully submitted,

Sheldon I. Miller, M.D.
Director of Scientific
Affairs and Research
Advanced Health Systems, Inc.

SIM:r

Enclosure

STATEMENT OF THE

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Mr. Chairman:

The National Association of Private Psychiatric Hospitals (NAPPH) is pleased to have the opportunity to testify on the subject of alcoholism treatment coverage under Medicare. NAPPH represents the nation's freestanding (non-governmental) psychiatric hospitals, encompassing a wide variety of treatment approaches and programs for the mentally ill. A vast majority of these hospitals also treat alcoholic patients. Many have highly specialized programs for alcoholics, and a few member hospitals have been working in this field for a century or more.

NAPPH would be seriously concerned by any move to restrict the current availability of inpatient alcoholism treatment to the elderly under Medicare. NAPPH strongly believes that access to high quality inpatient alcoholism treatment must be continued for those Medicare beneficiaries who need such care. The Association's Task Force on Alcoholism is currently developing a model alcoholism program which we would certainly share as the committee considers any changes in Medicare coverage for the treatment of alcoholism. NAPPH's formal position on alcoholism treatment follows.

Introduction

During the past few years, private psychiatric hospitals have become concerned over major changes in public policy regarding psychiatric treatment programs for alcoholics. The trend to restrict reimbursement for the treatment of alcoholism in psychiatric hospitals deprives patients of services which have been demonstrated effective for many but, more importantly, necessary for some. The NAPPH, therefore, feels that given the collective clinical experience of its member hospitals, the Association can make valuable input to public policy in the area of alcoholism treatment. The NAPPH hopes to communicate to others in the field, both providers and payors, those concepts and values which it feels are essential to effective therapy.

A major thrust in the alcoholism field in recent years has been the development of a wide variety of nonmedical treatment programs, both residential and ambulatory, which include detoxification, intermediate, and long-term care. These programs are almost universally oriented toward the Alcoholics Anonymous philosophy and have given birth to a new type of paraprofessional, the alcoholism counselor. Psychiatric input in these programs is ancillary and limited to the treatment of coincident psychiatric illnesses. Most such nonmedical programs and the paraprofessionals staffing them claim that all alcoholics can be treated in this educational-inspirational-socialization model, and that the psychiatric treatment of alcoholism is wasteful of resources and perhaps even harmful to patients.

Influenced by this thinking, a number of state legislatures, federal and state regulatory agencies, insurance programs, and prepaid medical service plans such as Blue Cross have taken steps to limit third party payment for alcoholism treatment to these nonmedical facilities. Furthermore, they tend to limit hospitalization coverage to a brief detoxification period. The NAPPH, being alarmed by this movement toward the elimination of the psychiatric treatment of alcoholism with the resulting loss to patients, is prepared to work with other providers, third party payors, and consumers toward a comprehensive, pluralistic effective model of alcoholism treatment.

Background Issues

1. Alcoholism can be broadly described as a chronic illness in which repeated use of alcohol is associated with the impairment of physical health, emotional and mental stability, occupational and social functioning, and family or other interpersonal relationships.
2. The etiology of alcoholism has been attributed to a variety of causative or contributory factors, including genetic, constitutional, nutritional, psychological, family, social, and cultural. Each of these factors has, now and in the past, strong advocates for its primacy and none can be excluded by current research.
3. The course and outcome of alcoholism is highly variable; one alcoholic may deteriorate and die within a decade with the alcohol abuse pattern as another whose half century of alcoholism leads to only mild impairment or a slightly premature death. For some, social impairment and occupational disability occurs within a few years of starting to drink, while others may perform adequately for many years in spite of daily consumption of prodigious amounts of alcohol. It is often difficult with any particular patient to determine where on the continuum of alcoholic impairment a patient rests and in which direction he is moving.
4. All treatment modalities for alcoholism have been empirically developed, usually without clear relation to any comprehensive theory of etiology. Surely this is true for Alcoholics Anonymous, group or individual psychotherapy, Antabuse therapy, and aversion therapies. Much more research needs to be done to develop a more comprehensive theory of etiology which can then influence treatment methods.

The Multidisciplinary Team

A consideration of the four concepts outlined above indicates that alcoholism treatment programs must consider each patient as a complex bio-psycho-social being with a unique combination of impairments, assets, and treatment needs.

From this perspective, treatment planning must be highly individualized, and the ongoing evaluation of progress must consider each of the variables influencing the patient's illness. This requires the efforts of a multidisciplinary team able to evaluate the patient from the medical, psychological, social, and spiritual perspectives; able to define the patient's diagnosis and treatment needs; and able to prescribe and implement specific therapeutic interventions. In the traditional psychiatric hospital, this multidisciplinary team operates under the supervision of a psychiatrist and has included such professionals as psychologist, social worker, nurse, occupational therapist, pastoral counselor, and medical specialists such as neurologists and internists. In recent years the addictions counselor has brought to this treatment team his unique perspective and ability to therapeutically engage some patients. In this environment, the patient is viewed not as the property of any single profession or theoretical orientation, but rather as a complex person whose needs require the efforts of different disciplines at different stages of treatment.

Alcoholism as a Psychiatric Illness

In recent years there has been criticism of the so-called "medical model" in the treatment of the psychiatrically ill generally, and towards alcoholics specifically. These critics have neither clearly understood the medical model nor the disease, alcoholism.

An example of a disease which parallels alcoholism is diabetes. In diabetes etiological factors are as diverse and multiple as in alcoholism, its course and outcome are as variable, and its treatment is as complex and individualized. Superficially, it would seem that the diagnosis of diabetes (by level of the blood sugar) and its treatment (controlling blood sugar by diet and drugs) is very simple and straightforward, especially since enormous advances have been made in understanding body chemistry during the past four decades. In reality, the treatment of diabetes is quite variable and often complex. It requires the efforts of many disciplines and involves the patient's emotions, will, intellect, and social environment as well as his blood sugar. Acceptance of this illness and development of a new style of living are as important for the diabetic as they are for the alcoholic. Denial and rationalization of either illness can lead the patient into relapse. Like alcoholism, the course of diabetes is variable. Some patients, after a diagnosis and prescription of a diet, may do so well that only an annual checkup is needed to verify their success in controlling their disease. However, others may never be able to follow a course of treatment and may have repeated crises with the possibility of rapid deterioration and death. It is clear to all who treat diabetes that the psychological strength and social assets of a patient are as important as anything else for the successful outcome of treatment. For diabetics, a competent physician is essential to proper evaluation, diagnosis, and prescription of treatment. However, an understanding, persistent, and well-trained nurse-educator is also a key person in initiating and maintaining successful treatment. It should be clear, then, that medicine in general, and psychiatry specifically, have always dealt with complex chronic illnesses like alcoholism, and have in recent times cooperated with a wide range of other professionals to provide effective comprehensive treatment. In the treatment of alcoholism this is exemplified by the multidisciplinary treatment team utilized within the psychiatric hospital.

Treatment Settings

Outpatient - It is clear that some alcoholics do not require inpatient treatment. Some will succeed as outpatients, or in partial hospitalization programs. Those most likely to succeed as outpatients are:

1. Those who are medically stable, having only mild withdrawal symptoms.

2. Those able to stop drinking without continuous supervision and able to remain abstinent long enough to become involved in therapy.

3. Those motivated for long-term outpatient therapy and participation in supportive groups such as Alcoholics Anonymous.

4. Those supported by a stable family, and/or social and occupational system willing to participate in therapy.

The NAPPH hopes that the development of outpatient and partial hospitalization programs for the treatment of alcoholism will be continued and expanded.

Inpatient - When does the alcoholic need inpatient treatment? Given differences in theoretical orientation, professional training, the availability of programs and financing, there are many conflicting answers to this question. We, however, decided to use PSRO criteria for admissions review of alcoholics. These are narrow and restrictive criteria, but do have widespread acceptance and, therefore, are easily cross-validated by different professionals and institutions. By these criteria, an alcoholic should be hospitalized when one of the following is present:

1. There is a life-threatening medical condition.

2. The patient is dangerous to himself or others.

3. There is an impairment of mental and/or physical functioning or alteration of mood sufficient to interfere substantially with the capacity to meet the ordinary demands of their familial, occupational, or social environment.

4. There is a requirement for continuous, skilled staff interventions and observations to safely detoxify the patient and to observe and confront the patient with the interaction between drinking and every other aspect of functioning.

5. The patient has failed to respond to treatment at alternate, less restrictive levels of care such as outpatient or daycare.

These criteria for inpatient treatment indicate the unique role of the hospital in approaching this illness. The first three criteria are indicators of concurrent severe illness, sometimes sequelae of alcoholism, which in themselves require hospitalization. The fourth criterion reflects the significant medical risks of alcohol detoxification and the fact that the alcoholic is highly susceptible to relapse. Likewise, the fourth criterion recognizes that some alcoholics are unable to initiate and sustain abstinence unless they are in a program which isolates them from alcohol during the crucial early phases of treatment and helps them overcome resistance to treatment.

Two major issues arise in current discussions of inpatient alcoholism treatment. First, do patients require inpatient care following detoxification. Second, if intermediate inpatient care is required, should it occur in a hospital or in a nonmedical alcoholism treatment facility? Therapists from many disciplines agree that a substantial number of alcoholics require a period of inpatient treatment at least several weeks in duration after detoxification. Without such care they are highly likely to relapse and begin another cycle through the revolving door of detoxification and relapse. The follow-up statistics for those receiving such inpatient care are clearly better than for those receiving detoxification alone.

The second question, the setting of intermediate inpatient care, can only be answered after a thorough diagnostic evaluation of the patient. Treatment results in all settings will improve as individual treatment needs are better identified by sophisticated psychiatric diagnosis and matched with appropriate treatment modalities.

In a psychiatric hospital alcoholism program, the initial phase of hospitalization involves not only detoxification, but the simultaneous initiation of a thorough evaluation and diagnostic formulation by a multidisciplinary team. Within one to two weeks of admission, most patients are sufficiently free of the toxic effects of alcohol and the symptoms of the withdrawal syndrome to be accessible for definitive evaluation so that a comprehensive treatment plan can be formulated. At this time, the patient can generally be placed in one of four large groups, each with differing treatment needs.

I. When alcoholism occurs in conjunction with a major mental illness (most frequently a manic or depressive psychosis, or a chronic schizophrenic illness), the patient must be treated in a psychiatric hospital where appropriate therapy (usually including medication) is available and where disturbed behavior can be handled. These patients should also receive concomitant therapy for alcoholism with special emphasis on the pattern of using alcohol as self-medication for their mental illness. Treating the psychosis alone may leave the patient vulnerable to alcoholic relapse. Although these patients are a distinct minority among alcoholics, their number appears to be increasing. Also of importance is the recent evidence that manic depressive illness is accompanied by a high incidence of alcohol abuse, especially during acute episodes of mania or depression when alcohol is used in an effort to regulate mood and sleep patterns.

2. Alcoholics with serious medical or neurological complications should also receive concomitant therapy for alcoholism and their physical disease. Ths includes not only those with obvious medical problems such as liver or cardiac failure which need close medical and nursing supervision, but also the significant number of severe alcoholics who, after detoxification, show a persisting organic mental impairment which may take weeks or months to recover and in some instances will never recover fully. Detecting and measuring such a deficit may require cooperation of several members of a hospital team. Planning the immediate and long-term treatment for such patients requires continued reevaluation by the same team. If therapy for the addiction waits for the patient to recover from the physical illness, not only may valuable time be wasted, but the patient may reconstitute his denial mechanisms and be unavailable for futher therapy. The psychiatric hospital, with its medical, neurological and psychiatric treatment capabilities, is the only institution able to offer these patients truly comprehensive treatment.

3. Other alcoholics requiring concomitant psychiatric and addiction treatment are those who have a significant neurotic illness or personality disorder reciprocal with the alcoholism which in itself requires intensive psychiatric therapy. Among those with neurotic disorders, symptoms of anxiety, depression, insomnia, marital conflict and sexual dysfunction are common. Alcohol may be used for self-medication to control these symptoms. These neurotic disorders usually have a clear relationship to a significant loss or to the failure to work through a developmental crisis (such as parenthood, emancipation of one's children, menopause, a change in job, retirement, and aging). Dysfunctional drinking at these times often serves the neurotic need to perpetuate problems in a self-defeating way just when success is within reach. The

rapid development of alcoholism in the middle-aged or older person of previously moderate habits strongly suggests the possibility of such a reciprocal neurotic disorder. The reciprocity mentioned here is a critical concept: For the neurotic, excessive alcohol use will only briefly diminish symptoms but, in the long run, will subsequently worsen them and ultimately further undermine the patient's already diminished self-concept and ability to cope with stress. An attempt to treat the addiction alone may leave the patient with intolerable depression or anxiety leading to relapse generating further demoralization or neurotic guilt. Likewise, outpatient treatment of a neurotically disordered patient while the alcoholism is active is likely to fail, since the drinking will defeat attempts to intervene therapeutically, will perpetuate the symptoms, will stimulate more guilt, and will inhibit new learning. In these patients, the neurotic symptoms and the alcoholism are mutually causative, complicating and intensifying each other, and cannot be treated in isolation.

In those alcoholics who have an underlying severe personality disorder, the treatment difficulties are quite complex. These patients (who are on the average younger than those with neurotic disorders) have lifelong personality dysfunction with disturbed interpersonal relations and social functioning. The borderline, inadequate, hysterical, explosive, and sociopathic personality types are among those most often associated with alcoholism. For these patients alcohol may be used not only for self-medication of symptoms like depression or anxiety, but may be used as a defense mechanism specific to the patient's disturbed relationships. Examples of the latter include drinking as an acting out of conflict with society or authority (seen especially in adolescents), as an effort to manipulate others, as a self-destructive act, for the disinhibition of sexual or aggressive impulses, or conversely, for the control of drives or impulses. The onset of alcoholism in adolescence, or the presence of violence, promiscuity, criminality, or self-destructive behavior in states of intoxification strongly suggests that the addiction is associated with one of these personality disorders. The high failure rate of many adolescent addiction programs is likely due to the failure of such programs to recognize and treat the underlying personality disorders.

Psychiatric hospitals have extensive experience treating such combinations of problems increasingly found among adolescents and young adult patients. It is recognized that therapy in such cases must be long-term, must take place in a setting free of intoxicants, and must aim toward growth and reorganization of the personality. For patients with these severe personality disorders such a therapeutic program is possible only in a psychiatric hospital setting where a skilled, trained staff is available to plan and carry out such treatment.

In summarizing the problem of the alcoholic with a neurotic or personality disorder, it is crucial to recognize that the two illnesses become a unitary process in a single human being. To treat one or the other alone is to ignore the whole person.

4. Another large group of alcoholics are those who, after detoxification, have no significant medical or psychiatric illness. Although some of these patients may experience mild degrees of depression, anxiety, guilt, irritability, insomnia, loss of appetite, or other psychosomatic disturbances, these symptoms usually resolve within a few weeks and are clearly a consequence of alcoholic addiction. Many of these patients possess lifelong neurotic traits or personality disturbances (such as stubborness, excessive dependency, or inappropriate aggression), but these do not appear to be reciprocal with the alcoholism and are not an obstacle to abstinence. The patient might benefit from inpatient psychiatric therapy for such problems, but such therapy is not essential to successful alcoholism therapy.

This last group of patients may be treated successfully in non-medical alcoholism treatment facilities. Facilities of this sort should actively involve the patient's family in therapy and work with employers and others in the patient's life to assure successful adjustment after discharge. They should also involve the patient in an active aftercare program which might include Alcoholics Anonymous.

We feel strongly that any benefit package must take into account these four groups of patients with their varying treatment needs and must avoid unrealistic limitations on the availability of appropriate treatment. All alcoholic patients deserve the type of diagnostic evaluation described above.

Length of Stay

Many inpatient settings are organized around a standard four-week program of therapy. This length of time may be adequate for the majority of uncomplicated alcoholics, but for a substantial number of patients a longer period of inpatient treatment is necessary for a successful outcome. This is especially true for patients whose family and social supports have been eroded by prolonged addiction. Experienced psychiatrists can usually predict early in treatment which patients will require a longer stay. Justification of additional care can be made in terms of clearly defined factors in the patient's history, mental state, motivation, attitude toward treatment, and social support system.

Aftercare

No patient's treatment plan can be considered complete without a plan for aftercare. It has been empirically demonstrated that success in maintaining sobriety is equated with success in maintaining an effective aftercare program. Such a program should be an integral part of all alcoholism treatment programs and should be individualized to meet each patient's treatment needs. Medical insurance plans must be required to include reimbursement for aftercare.

Assuring Access to Care

The treatment plan and treatment setting should be determined by patient and physician after a comprehensive diagnostic evaluation. Third parties, be they payors, unions or employers, should not arbitrarily preempt this decision, especially since appropriate treatment invariable is cost-effective.

STATEMENT
OF THE
NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS
ROBERT RUNDIO, PRESIDENT

Mr. Chairman and Members of the Committee:

On behalf of the National Association of Alcoholism Treatment Programs, we express our appreciation for the opportunity of entering this testimony and supporting documents for the permanent hearing record.

The National Association of Alcoholism Treatment Programs (NAATP) was founded in 1978 to represent private sector providers of care to victims of alcoholism and their families. We currently represent more than 250 facilities throughout the United States, comprising non-profit, proprietary, free-standing, hospital-based, residential and outpatient alcoholism treatment programs. Our goals, as a leadership organization in the chemical dependence field, are to maintain visibility for the idea of alcoholism as a treatable disease; to secure more specific and appropriate treatment standards and more adequate third-party reimbursement for services; to create in the public's mind a distinction between alcoholism treatment and treatment solely designed to deal with mental illness; and to maintain programs of continuing education for those who administer and coordinate alcoholism treatment programs. Our organization serves on the Steering Committee of the National Coalition for Adequate Alcoholism Programs and as official liaison from the alcoholism treatment field to the Joint Commission on Accreditation of Hospitals. We consider ourselves an active participant in the national private health care provider movement and truly believe that our member programs, through their commitment to our organization's Principles of Practice, provide high quality care in this most crucial health area.

The issue of medicare financing of alcoholism treatment, with which this distinguished Committee is dealing today, is one whose importance should not be underestimated. Encompassed in the scope of the topic are a variety of considerations, including, but certainly not limited to: governmental role in health care financing; ascertainment of population at risk; appropriate levels of care for the disease of alcoholism; reasonable and adequate definitions of "treatment;" impact of the medicare reimbursement model on health care and private financing mechanisms. Indeed, these are complex issues requiring an in-depth analysis of current patterns and prospects for the future. More scientifically-oriented organizations and spokespersons can address many of these issues with greater clarity and authority than we; but we do believe we have a valid point of view, based on the collective treatment experience of our many member programs. We hope to provide--through this testimony and, we trust, on a continuing basis as an organizational resource to the Committee--appropriate baselines of consideration for the formation of realistic and humane approaches to the treatment of this chronic, progressive and potentially fatal disease.

Medicare recipients, as representative of elderly Americans, generally, are an interesting and viable population to study in order to ascertain appropriate approaches to the treatment of alcoholism. Current studies indicate that 2%-10% of the nation's eldely suffer from alcoholism. Further, this alcoholic sub-population has, through valid research, been divided into two distinct groups: early-onset alcoholics and late-onset alcoholics. Definitionally, early-onset alcoholics are those persons who have been drinking alcoholically for several years, starting in the middle years and progressing to older age. The late-onset alcoholics began abusive drinking in the later years, most likely in response to the various physical and psychological stresses of advanced age. Our best research suggests that the former group, the so-called early-onset alcoholics, comprise some two-thirds of the elderly alcoholic population. According to a noted researcher in the alcoholism field, Dr. Sheldon Zimberg, "...Although there may be different etiologic factors associated with the development of alcoholism in these two groups of elderly alcoholics, it has been the experience of clinicians that both groups respond well to appropriate therapeutic interventions."[1] The important messages in Dr. Zimberg's conclusion are the positive responses and the appropriateness of approaches. They are, in fact, very clearly related. It is our position, based on experience, that just as is the case in other chronic disorders, a variety of multi-level approaches must be preserved and maintained for alcoholic patients, in order to provide the most effective and efficient care.

Currently there rages a somewhat specious debate over just what does constitute "effective" care for the alcoholic patient. The manifestation of this debate is a controversy which emerges as "inpatient treatment versus outpatient treatment." This is little more than a simple and appealing way to proffer the argument that "cheaper is better." Unfortunately, comparing the outcome success of inpatient and outpatient alcoholism treatment programs, and their attendant costs, per se, obviates the most crucial part of the puzzle: the populations being treated. As a treatment association, we would not take issue with statistics which would seem to indicate that outpatient alcoholism treatment and inpatient treatment are similarly successful. We would further demur from arguing that outpatient treatment is generally less costly than inpatient. What we would caution against, is an interpretation of these facts that suggests outpatient treatment is always "better," merely because it is effective and less expensive. In fact, isolating the above-mentioned data, one can only draw the conclusion that alcoholism treatment--period--is successful. With that we concur. But the question must be raised, "What kind of treatment and for whom?" This question seems somehow to be left behind by those who would blithely compare the apples and oranges of inpatient and outpatient care.

Inpatient care is most successful when directed at the appropriate patient and the exact same statement would apply to outpatient treatment. All alcoholic persons are not the same, just as all cancer victims and patients with heart disorders are not the same. The disease of alcoholism, owing to its chronic and progressive nature, manifests itself in various stages. In earlier stages, outpatient treatment can be best. In middle and later stages, residential or hospital-based treatment can be best. The point here is that diagnostic decisions are best made by trained alcoholism treatment professionals, not by the federal government, private insurors or patients, themselves. We would no more place a person in the midst of alcoholic psychosis in an outpatient program than we would a teenager getting drunk once every six weeks in an inpatient program. While this comparison may seem outlandish, it is no more so than the philosophy which implies that alcoholics are somehow wholly undeserving of any level of care, save the lowest and the least expensive. Low cost and effectiveness must not be equated. Indeed, many alcoholics respond solely to Alcoholics Anonymous. Others need only a half-way house. Still others need outpatient care. Some respond to residential care. Some respond to hospital-based treatment. Some need nothing more than the decision to stop drinking. But for those who need care, at any level, we feel it imperative that the appropriate level of care be available. Otherwise, we, ourselves, perpetuate the stigma of this often misunderstood disease.

Medicare reimbursement for alcoholism treatment should be broadened, not diminished or restricted. The three major levels of care--outpatient, residential and inpatient--must be available to elderly alcoholics, with a trained treatment professional making the decision as to the appropriate level of care. Given the many physical/psychological disorders afflicting the elderly, and complicating, if not exacerbating those problems with abusive drinking, it is vital that elderly, early-onset alcoholic medicare beneficiaries have maintained for them unfettered access to hospital-based and residential treatment. Late-onset alcoholics, when absent dread medical complications, should have available to them appropriate residential and outpatient care. Treatment for alcoholism should be looked upon as a continuum and, in that regard, researchers Snyder and Way stress that an inpatient rehabilitation program for the elderly should be followed by involvement in an outpatient program or aftercare regimen.[2] Schuckit and Pastor suggest that, "The most logical health care approach would be a combination of the usual means of confrontation and treatment and special care to increased medical and social needs of people in this age group... alcohol can exacerbate pre-existing conditions, and when these circumstances combine with the generally decreased physical reserves of the elderly, treatment can be especially difficult."[3] We interpret these research findings as indicative of the need for the preservation of the broadest range of alcoholism treatment services, in addition to a call for more reimburseable services under medicare.

In order to make the medicare program truly responsive to the needs of elderly alcoholics, NAATP recommends the following changes in reimbursment restrictions:

1. Expansion of rehabilitation days (exclusive of detoxification) from 21 days to 28 days, to accomodate regimens utilized effectively by both hospital-based and free-standing residential programs, when such is indicated as appropriate by a qualified diagnostician.

2. Coverage for outpatient services for up to 104 visits per year, when such is indicated as appropriate by a qualified diagnostician.

3. Coverage of aftercare programming or outpatient services as follow-up to inpatient or residential treatment, when such is indicated as appropriate by a qualified diagnostician.

4. Coverage for family treatment, regardless of modality or setting, when such is indicated as appropriate by a qualified diagnostician.

According to Zimberg, "Treatment approaches for elderly alcoholics are most likely to be successful if directed at the social and psychological stresses associated with aging. Therefore, group socialization, social case work, family case work, the use of antidepressant medication for the clinically-depressed, and medical care for physical problems are the treatment of choice."[4] Again, a call for the broadest range of services available. We believe the changes we call for in medicare reimbursement for alcoholism treatment will provide just such a range.

We have included two attachments to our testimony, which we respectfully request be made a part of the permanent hearing record. Attachment I is the NAATP's Principles of Practice, to which all alcoholism treatment programs who are NAATP members faithfully subscribe. Attachment II is our position statement on the ideal private insurance benefit package. We hope the Committee will find these documents useful.

We are very grateful to the Committee for its invitation to enter this statement on this most important and historic hearing. We hope you will continue to look to the National Association of Alcoholism Treatment Programs as an informational resource in this area.

REFERENCES

1. S. Zimberg, "Diagnosis and Treatment of the Elderly Alcoholic," Alcoholism: Clinical & Experimental Research, Vol. 2, No. 1, pp. 27-29, 1978.

2. P. K. Snyder, A. Way, "Alcoholism and the Elderly," Aging, 291: pp. 8-11, 1979.

3. M.A. Schuckit, P.A. Pastor, Jr., "The Elderly As A Unique Population," Alcoholism: Clinical & Experimental Research, Vol. 2, No. 1, pp. 60-67, 1978.

4. S. Zimberg, ibid.

ATTACHMENT I.

NAATP

PRINCIPLES OF PRACTICE

Preamble

Definition

We, of the National Association of Alcoholism Treatment Programs, Inc., believe and endorse the concept that alcoholism and chemical dependence are complex family illnesses in which an individual's ingestion of alcohol and/or other chemicals seriously and/or repeatedly interferes with health, job performance, family welfare and/or interpersonal relationships.

Philosophy

Alcoholism and chemical dependency are primary illnesses that can be successfully treated and arrested; through education, early intervention and treatment, recovery from illness can be accomplished. We also believe that alcoholism is not a mental disorder, nor is it a matter of morals, intellect or willpower, and that the stigma often associated with alcoholism and chemical dependence is both unwarranted and out of date.

We further believe that a person with alcoholism and/or chemical dependence can never return to the use of alcohol or addicting chemicals without adverse effects. A return to drinking or use of other addicting drugs at any point during recovery must be viewed as a relapse in the recovery process and not a sign of failure of the individual or the program.

Therefore, our primary goals in the treatment of alcoholism and chemical dependency are for each individual to strive for and attain abstinence and to improve the level of functioning of the individual and the family members, particularly in the area of interpersonal relationships.

Principles of Practice

The Principles of Practice is a statement of tenets for member programs of NAATP. As such, they reflect a standardization in terms of philosophy, language, and goals of member programs. This is not meant to limit flexibility in terms of program structure or treatment modalities. These are principles to which member programs of NAATP commit themselves.

Three major categories provide the framework for a philosophy of alcoholism programs; these include principles of treatment, management, and facilities.

Alcoholism treatment programs are catalysts for action in all areas surrounding the alcoholic. Alcoholism treatment programs act as one among many resources for a community dealing with the problems of alcohol abuse and alcoholism but by nature, are leaders in featuring quality care on all levels. Alcoholism treatment programs promote dialogue and cooperative relationships with all aspects of the caring community for the alcoholic. Such aspects minimally include viable industry, effective treatment programs, third-party support, and long-term follow up care, as well as fellowships of self-help groups. As member programs, we are dedicated to the concept of helping people who suffer from the disease of alcoholism and other drug dependencies to establish health through the achievement of freedom from mindaltering drugs or chemicals.

Treatment Principles

We believe that . . .

. . . levels of care and specific services provided should be defined to meet the appropriate physical, emotional, social, and spiritual needs of the patient

. . . treatment should include the family, employer, and significant others

. . . the overriding goal for patients of any treatment program is defined as self-actualization and an improved quality of life, not assistance alone

. . . each patient should receive a thorough and continuous assessment during all phases of treatment resulting in an updating of individual treatment and continuing recovery plans

. . . the primary functions of treatment programs are the identification, evaluation, and treatment of persons experiencing problems related to alcohol and/or drug use

. . . programs should have both a patient rights statement and a patient responsibilities statement

. . . programs should enhance the dignity and protect the human and legal rights of the patient by promoting self-respect, preserving individuality and protecting the need for privacy and confidentiality

. . . programs should have a definitive after-care program which supports the continuing recovery of patients and their families

Management Principles

We believe that . . .

. . . the governing authority should clearly state organizational goals and objectives
. . . programs should be committed to provide treatment by an interdisciplinary team of competent staff whose members subscribe to professional standards in their respective fields
. . . programs should seek community input to programming and evaluation on all levels including services, treatment management, and facilities
. . . programs should be an integral part of a community's human services system
. . . programs should clearly communicate their fee structure with the consumer
. . . a program should not discriminate against any person at any level
. . . programs should have internal evaluation of patient care

Facilities Principles

We believe that facilities should . . .
. . . meet all local, state, and federal life safety, occupational safety, health and fire codes
. . . be accessible to the handicapped
. . . be comfortable so as to enhance the dignity and rights of every patient

CODE OF ADVERTISING ETHICS

As an organization of private-sector alcoholism treatment programs, we recognize and support the right of our members to utilize public relations and advertising techniques to publicize their existence and worthiness. Whether through print or electronic media, such advertising shall comply with these Principles of Practice, providing such advertising . . .

. . . Meets community and industry standards of ethics, decency and good taste;

. . . Stresses the positive nature of the treatment program advertised, on its own merits;

. . . Refrains from negative statements or implications about other alcoholism treatment programs;

. . . Emphasizes the effectiveness of alcoholism treatment without referring to specific and/or absolute percentages of recovery; and

. . . Does not imply or express that the alcoholism recovery and rehabilitation process is patently simple, comfortable or effortless.

STATEMENT OF WILLIAM N. PLYMAT

Mr. Chairman, and members of the Subcommittee. I am William N. Plymat. I live at 2908 Patricia Drive in Des Moines, Iowa. I am a member of the Iowa Commission on Substance Abuse and last year served as Chairman. This year I was re-appointed to a second four year term on the Commission by Governor Robert D. Ray of Iowa. I am a retired Iowa State Senator, and am a lawyer. I am Executive Director of the American Council on Alcohol Problems, and Board Chairman Emeritus, of the Preferred Risk Mutual Insurance Company of Des Moines.

I have been involved in programs responding to the problems of alcoholism for well over 40 years. I've been involved in the study of many types of therapy for this disease and/am personally knowledgeable about the general effectiveness of various therapy programs. I know that your Committee is seeking to find the best and most cost effective treatment for the disease. As you focus your attention in this effort I believe it is important for us to first take a careful look at the nature of this disease. Many people and groups view it as just a psychological problem and thus sincerely believe that all that is needed is to detoxify the victim and then provide in depth lectures which simply direct attention to the need for the victim to seek permanent sobriety. I believe that much more than this is involved in many if not most of the cases.

THE CAUSES OF THE DISEASE

A doctor who was a pioneer in efforts to cope with alcoholism wisely said this disease involved "an obsession of the mind" and an "allergy of the body". Many views have been voiced about why a minority of our citizens become addicted to alcohol. About 10% of those who do become addicted say they became that way almost from the first drink. The rest require varying amounts of time--most often ten years or more of increasing drinking. We know that people with a variety of mental problems turn to alcohol to alleviate their frustrations in life. Yet evidence shows that people from some genetic backgrounds seem especially susceptible to addiction, and those from other such backgrounds are low in susceptibility. It is contended by some that those whose bodies react to sugar in one way are easily addicted while those with other reactions are not. I have been interested to observe the excessive use of sugar by many who seem to have been able to break their addiction to alcohol, but then become heavy users of sugar. The director of a mission for alcoholics who have no funds pointed out the high usage of sugar in his mission. He said that these men would do menial tasks for low pay and put their money in a candy machine when they returned to the mission.

Mounting evidence reveals that heredity plays a role. It is still arguable whether is due to a learned response from the previous generation or some biological factors. And it even has been contended by some that there is a hormonal factor present and that very few bald-headed males become alcoholics.

Dr. Jorge Valles M.D. for many years served as Director of the Alcoholism Unit, and Treatment and Research Program of the U.S. Veterans Administration Hospital in Houston, Texas. In addition he was Clincial Assistant Professor of Psychiatry, of the Baylor University Collegce of Medicine. He is author of a book titled: "From Social Drinking to Alcoholism" and a highly regarded expert in the field. Chapter X of his book is titled: "The Autonomic nervous system and the hypothalamus". In this Chapter Dr. Valles presents his case for his belief that alcoholism springs from the effect of alcohol on the hypothalamus. He contends that the fact that many youth under 21 are rather quickly addicted to alcohol is due to the fact that their hypothalamus has not not reached a full physical maturity. And that until the organ reaches full maturity it is very sensitive to alcohol. He explains that the reason that an alcoholic who has had apparently a successful therapy cannot return to social drinking is due to the damage the drug does to this section of the brain. He further says that this damage may account for a chronic alcoholic's resistance to therapy under certain circumstamces. regardless of his efforts or tnose of the therapist.

Dr. James W. Smith, Medical Director of the Schick-Shadel Hospital in Seattle, which has a 40-year record of successfully treating alcoholics, contends that the incidence of color-blindness in alcoholics is greater than in the general population; that blood group "A" is found in alcoholics more often than in the general population; that a disprortionately high percentage of alcoholics are unable to taste the chemical phenolthiocarbimide; that alcoholics in contrast to non-alcoholics show abnormalities in adrenal gland function, regulation of blood presure, metabolism of glucose; that two enzymes produced in the liver have been found to be at different levels in the case of alcoholics in contrast to non-alcoholics; and that alcoholics break down one amino acid to one abnormal product while non-alcoholics break the acid down to a normal end product.

All this points to the possibility, if not probability, that those who become "hooked" on alcohol may be physically different from those who do not.

I believe that all the facts cited by Dr. Smith are valid and relevant to a consideration of the best and most cost effective treatment for this disease.

I further believe that addiction to alcohol is buried deep in the subconscious mind, due to associations, ideas, and thoughts implanted over gradually increasing usage of alcohol. The user, in effect, loses in the end any possible ability to decide whether to use or not use this drug.

It is well known that persons who have been addicted to alcohol and then stop drinking for a long period of time experience a powerful craving for the drug. This craving appears responsible for many slips by these persons.

I am convinced that the most successful therapy involves the use of aversion therapy which the Schick Hospitals use. They give the victim freedom from this craving. And they do this in a short period of time, usually around ten days. I believe with such freedom from craving there is a much less danger of a slip than is the case when a therapy is based mostly on an attempt to convince the victim to resist his craving.

The Schick therapy has been subjected to a careful examination of their outcomes which the members of the Committee should carefully examine.

In my state $2,500,000 is provided by the State to pay for therapy work in a large number of agencies. Yet I do not believe there is a record of the success records as in the case of the Schick system. Because I know of the powerful power of craving I can not believe that the slip records of those who use persuasion only even when supported by the dedicated people who have found sobriety can equal the record of Schick.

When confronted by success stories of the Schick therapy some who feel other methods are superior have attempted to explain away the Schick success record by saying that people who pay a considerable sum for help are strongly motivated to find sobriety while those who just go to some free or low cost programs are not. This argument can easily be met by the many Schick cases which involve people who had their treatments paid by public sources and relatives and friends.

THE SIZE OF THE PROBLEM

In considering fruitful programs and efforts to meet the problem of alcoholism I think it is wise to realize the size of the problem and all the efforts that carried on to meet it. I should like to cite the facts of my home State of Iowa. Iowa has a population nearing 3,000,000. Our Substance Abuse Commission receives approximately $2,500,000 in state money and about the same amount in federal funds. Of this $800,000 is needed for administration. About $750,000 goes for prevention activites. This leaves $4,000,000 for treatment work carried on in 28 major programs which serve 90 of 100 counties with offices. In addition cities and counties expend money in various ways which wind up the total for the state of $12,000,000. There are a large number of private hospitals that render services to those who pay for services and there are large number of Alcoholics Anonymous groups that serve a large number of people.

Up to this time I believe there is no study of any kind that indicate the long term effects of all this work. We all know that the only answer to the problem of alcoholism is total abstinence and that sooner or later those who fail to achieve it on a long term basis die. I believe that success should only be viewed as efforts that achieve this goal. I believe that we need to have a study that covers all who are served to determine how many find permanent abstinence. This is turn can indicate the true cost effectiveness of the various programs and therapy facilities.

AN EXAMPLE THAT ILLUSTRATES THE NEEDED FOCUS

When I was a member of the Iowa Senate in 1972 I was concerned about the lack of evidence on successful outcomes with total abstinence. I then represented the Iowa Senate as a member of the Alcoholism Commission of the State. I heard rumors that there were many who went to one agency for treatment sobered up and then shortly thereafter went back to drinking and went to another agency in another town or city. Further that in some cases this was repeated many times. I urged that agencies assign some identification number to be filed in the headquarters of the Commission so that persons seeking help could realize that they might not be able to do this. I felt that they might be encouraged to keep sober after a first treatment and not think they could seek constant help. At first this was not done but sometime ago the social security number of the person was filed with State which has filled this gap.

As I sought to find the best answer to this problem I learned of the success of the Schick-Shadel Hospital in Seattle. At my prompting three men were sent up to the Seattle Hospital for treatment. One was a man who frankly told those who offered this help free to him that he did not think that any group could achieve permanent sobriety with him. He said he had been treated 13 times in Iowa at various places without success. He said he had been sober three months and three days in the preceding 25 years and I believe this involved public funds in each of these cases. He went to the Schick-Shadel Hospital in Seattle and found his alcoholism arrested for around 7 months. He did have a slip when he was injured in a factory job and also was suffering from migraine headaches. When I learned of this and confronted him with his situation and asked what he would like to do about it he very quickly said he would like to go back to the Schick-Shadel Hospital since it was the only therapy that stopped him from drinking. There is more to his story but not of importance to this point. Today he has had a good period of sobriety and tells me that he is confident he will never slip again. An interesting question is how much money had to be spent to bring him to successful sobriety.

The study of the Center for Organizational Research and Evaluation Studies of Texas Christian University which has been called to your attention by Dr. Barry S. Tuchfeld, another witness,is of special importance. This involved

458 new patients admitted for treatment in an eleven month period starting on February 1, 1979. The study showed that at the 18 month post-admission follow up 47.6% were abstinent and maintaining it. And of those who completed the prescribed treatment regimen/59% were abstinent. The study also showed that persons 60 years of age or older are more likily to maintain abstinence. This is of special importance to the focus of the Committee's concern. Although in-patient treatment at the Schick Hospitals involves a sizeable sum looking at the cost of returning an alcoholic to successful total abstinence over the period of the alcoholics remaining lifetime may be far lower than repeated treatments of greater number in some other facilities. Thus I believe there should be efforts to do studies such as been done in the case of Schick so that the best and most cost effective treatments can be adequately supported.

For the reasons I have set forth in my statement I feel that the Committee should carefully/study the testimony of the witnesses who have placed before the Committee the special treatment of the Schick Hospitals with special attention to the aversion therapy which I observe most patients feel is the most important element of that treatment. I also think the Committee should attempt to encourage a focus on treatment outcomes of various therapy agencies that seek public support. As near as I can tell in my State there is very little detailed information on outcomes. By making this statement I do mean to reflect on the efforts of any agency as I know that there are many very dedicated people who are striving to do the best they can to help those in need.

TESTIMONY

SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE

ON

MEDICARE COVERAGE OF ALCOHOLISM TREATMENT

Chaired by:

Senator David Durenberger

Submitted by:

Maurice Miller
President
National Council of Community
  Mental Health Centers
Washington, D.C.
July 27, 1982

Thank you, Mr. Chairman, for the opportunity to testify before you today on the need for Medicare coverage of alcoholism treatment.

My name is Maurice Miller, and I am the President of the National Council of Community Mental Health Centers. Our organization represents more than 800 community mental health programs throughout the United States; approximately 500 of the centers provide alcoholism treatment to significant populations within their respective communities of service.

The National Council recognizes alcoholism as a problem having vast and deleterious implications for our nation. Alcoholism is the nation's third leading cause of death today, and it is estimated that 30% to 50% of all hospital admissions are alcoholism-related. From an economic perspective, the costs of this disease are also profound. The Alcohol, Drug Abuse, and Mental Health Administration has estimated a total cost to society of $43 billion during 1975 alone due to alcoholism. We can be sure that an updated estimate for 1982 would be substantially higher.

Alcoholism afflicts the elderly as much as it does the general population. The NIAAA, in 1978, estimated that at least 10% of the nation's elderly experience serious drinking problems. Furthermore, NIAAA found that approximately 85% of the persons afflicted are not receiving services which relate to their alcoholism problems.

A major reason for this situation can be directly attributed to the inadequacies of the Medicare Program. The Medicare Program today singles out and restricts benefits to those suffering from mental disorders. Since Alcoholism has been categorized as a mental disorder by the Health Care Financing Administration, those who have contracted this disease are relegated to a status similar to others with mental and emotional problems. The 190-day lifetime limit on inpatient psychiatric facilities, the yearly $250 cap on physician services, and the 50% co-payment provisions are all serious limitations for older persons who seek quality alcohol and mental health treatment.

Of the 3-1/2 million clients served by our member centers in 1981, only 4% were Medicare beneficiaries, as compared to the more than 10% of the general population who are eligible for Medicare. We see this underutilization of community mental health services by the elderly as a manifestation of Medicare's bias in favor of inpatient, hospital-based, care. Particularly in the area of alcoholism treatment, inpatient hospital facilities can be substantially more expensive than both free-standing residential centers and outpatient facilities. In 1980, NDATUS reported average costs per client year of $13,730 for hospital-based treatment, $4,730 for residential free-standing treatment, and $740 for outpatient treatment. By encouraging the use of hospital-based care of alcoholism, Medicare reimburses the most expensive form of treatment despite the fact that community-based care is often preferred by persons suffering from alcoholism.

On the basis of the foregoing considerations, we respectfully recommend to the Subcommittee that participation in the Medicare Program be extended to accredited free-standing alcoholism treatment facilities and to comprehensive CMHCs providing these much needed services.

We sympathize with the difficulty of expanding health services in an era of mounting budgetary challenges. However, we believe that the final result of such an expansion will be cost-effective and cost efficient, since it will tend to reduce the utilization of more expensive alternatives. In addition, Medicare coverage for the free-standing alcohol detoxification centers was included in the Omnibus Reconciliation Act of 1980 (P.L. 96.499). However, last year this provision was repealed as part of the 1981 Reconciliation Bill.

Finally, the expansion of Medicare coverage for alcoholism treatment would: (1) address the unmet needs of the estimated 85% of the elderly who suffer from alcoholism induced problems and who receive no treatment; and (2) increase accessibility to alcoholism treatment by elderly Americans.

Thank you for encouraging this opportunity to present the views of the National Council of Community Mental Health Centers on this most important issue.

TESTIMONY OF

ACCURACY AND ACTION ABOUT ALCOHOL ADDICTION

Presented by Peter H. Meyers

Mr. Chairman and members of the Subcommittee:

I am honored to present this testimony on behalf of Accuracy and Action About Alcohol Addiction (AAAAA).

The Subcommittee's hearing today focuses on medicare coverage of alcoholism treatment services. AAAAA submits this testimony primarily to emphasize for the Subcommittee that there are a number of fundamental, generally-accepted principles involving alcoholism and alcoholism treatment services which the Subcommittee should consider.

AAAAA'S INTEREST IN THIS HEARING

AAAAA is a national, nonprofit, scientific and educational organization incorporated under the Non-Profit Corporation Act of the State of Washington. It is primarily concerned with the problems of alcoholism in our society, with the addictive nature of alcohol for many people, and with the treatment of alcoholics.

AAAAA seeks to insure that accurate information is available concerning the serious problem of alcoholism in this country, and strongly supports the need for effective laws to control the problems of alcoholism and alcohol abuse. For example, AAAAA was recently granted leave of court to file an amicus curiae brief in the United States Court of Appeals for the Fifth Circuit involving the issue of alcohol advertising. Lamar Outdoor Advertising, Inc. v. Mississippi State Tax Commission, No. 82-4076, U.S. Court of Appeals for the Fifth Circuit (Order issued June 17, 1982).

AAAAA was founded by individuals of national prominence who have extensive experience in the study and treatment of alcoholism, particularly through the Schick Hospitals. For example, Dr. James William Smith, Vice-President of AAAAA, has served as Medical Director of Schick Shadel Hospital in Seattle, Washington for more than twenty years, and has authored more than forty-five articles and other publications involving alcohol and alcoholism.

This testimony is presented by Peter H. Meyers, Esq., Adjunct Professor of Law at the George Washington University National Law Center. It emphasizes the general principles involving alcoholism and alcohol treatment which should guide the Subcommittee's consideration of these areas.

FUNDAMENTAL PRINCIPLES INVOLVING ALCOHOLISM AND ALCOHOLISM TREATMENT

1. Alcoholism is a disease. For many years, alcoholism was viewed as irresponsible conduct or as moral weakness. Today, it is generally recognized as a disease. See, for example, the statements submitted by the National Council on Alcoholism, and the American Medical Society on Alcoholism, to the Subcommittee.

2. Alcohol is an addictive drug for many people. Alcohol is a physically addictive drug in the same way that heroin and the narcotics are physically addicting drugs. All of these substances exhibit the classic characteristics of addiction: (1) an increased tolerance; (2) a strong compulsion to consume the substance; and (3) clinically observable symptoms of distress (withdrawal) when use of the substance is eliminated or reduced.

3. Alcoholism and alcohol abuse create significant social and financial costs in this country. Senator Durenberger stated this point graphically in the Subcommittee's Press Release of July 8, 1982:

> Alcoholism and alcohol related problems have resulted in significant costs to our Nation, in terms of human as well as financial resources. It has been estimated that alcohol related problems have had a cost of $28 billion in lost productivity, $18.2 billion in health and medical services, and $7.3 billion due to auto accidents involving drunk driving. Twelve to fourteen million Americans are believed to be struggling with an alcohol problem and the American Hospital Association estimates that approximately one-half of all occupied beds in the United States were filled by people with ailments linked to the consumption of alcohol.

4. Alcoholism and alcohol abuse are serious problems for all age groups, including the elderly population, who are the primary recipients of medicare benefits. As stated by Senator Durenberger, in the release of July 8, 1982:

> It has been estimated that as many as 15 percent of the elderly population, the primary recipients of medicare benefits, are believed to suffer from alcoholism. The Health Care Financing Administration, in fiscal year 1979, estimated that the medicare program paid about $100 million for the treatment of alcohol-based disorders and alcoholism.

5. Alcoholism treatment works. There is extensive documentation, from a variety of treatment programs, that alcoholism treatment is effective in combatting the addictive nature of the substance. Recovery rates of from 50 - 85% are not uncommon in alcoholism treatment programs throughout this Country. There is substantial evidence that many older alcoholics respond to treatment better than their younger counterparts. See, for example, the Statement of the National Council on Alcoholism to this Subcommittee.

6. There exist today a variety of effective treatment programs for alcoholism in this Country. The alcohol treatment system is marked by its diversity, and this is one of its important features that it is crucial to preserve. For many alcoholics, the most effective treatment will be intensive in-patient care in a hospital, but for other alcoholics, treatment in a "halfway house" or in an outpatient program may be adequate. The variety of treatment alternatives now available to alcoholics, their doctors, and their families, is a great strength in the system which should be encouraged and preserved.

7. Treatment for alcoholism makes good fiscal sense. Quite simply, it is cheaper to treat alcoholism than not to treat it. The American Hospital Association estimates that as many as one-half the hospital beds in the Country are filled with people with alcohol-related diseases. Even if only direct health care costs are considered, it is cheaper to treat alcoholism than to let it go untreated. Alcoholism treatment results in reduced health care costs not only by the alcoholic, but by his or her family as well.

AAAAA would again like to thank the Subcommittee for the opportunity to submit this statement of its views. AAAAA greatly appreciates this opportunity, and hopes that it has been of assistance to the Subcommittee in its deliberations.

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